Health Services
LOS ANGELES COUNTY

July 10, 2007

TO: Each Supervisor

FROM: Bruce A. Chernof, M.D.
Director and Chief Medical Officer

SUBJECT: **ATTACHED CMS PLAN OF CORRECTION DOCUMENTSFOR MLK, JR.-HARBOR**

Attached is one of two CMS Form 2567 Plan of Correction documents submitted today by MLK, Jr-Harbor Hospital as required to address the findings of the CMS survey of June 7, 2007 that were originally related to the neurosurgery transfer delay case. This Plan addresses the Medicare Conditions of Participation issues identified by CMS in this survey.

We have enclosed the entire Plan of Correction but not the related attachments, which are the policies, procedures and other documents related to the description included in the Plan.

In addition to this PDF version being forwarded to you tonight, we will also forward a hard copy version to your office tomorrow morning.

There will be a second CMS Form 2567 Plan of Correction that is being submitted today that will be sent in a PDF format late this evening to you that will be addressing the EMTALA violations identified on the same June 7, 2007 survey.

To avoid disrupting your computer system, we are sending this document in three parts.

If you have any questions regarding either of these documents, please contact John Cochran at 213 240 7926 or jcochran@ladhs.org.

BAC:jrc

Attachment

c: David E. Janssen
John R. Cochran, III
Sharon F. Grigsby

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To improve health through leadership, service and education.

MARTIN LUTHER KING, JR.
HARBOR HOSPITAL

July 10, 2007

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VIA FACSIMILE and UNITED STATES MAIL

Steven D. Chickering
Western Consortium Survey and Certification Officer
Division of Survey and Certification
Centers for Medicare and Medicaid Services
90 7th Street, Suite 5-300(SW)
San Francisco, CA 94103-6707

RE: Complete Survey Findings for Martin Luther King Jr.-Harbor Hospital, CCN: 05-0578

Dear Mr. Chickering:

Enclosed for your consideration are the Plans of Correction prepared by Martin Luther King Jr.-Harbor Hospital ("MLK-Harbor"), Provider No. 05-0578, in response to the Centers for Medicare and Medicaid Services' ("CMS") June 25, 2007, transmittal of the complete findings of its June 7, 2007 survey. One Plan of Correction relates to the five conditions of participation with which MLK-Harbor was found out of compliance, and the other relates to findings under EMTALA. Also enclosed are a series of attachments containing documents which substantiate the various corrective actions discussed in the Plans of Correction. It is our belief that these Plans of Correction, when considered in conjunction with the supporting attachments, contain credible evidence that the circumstances which led CMS to conclude that MLK-Harbor was out of compliance with the terms of its Medicare Provider Agreement have been remedied. Indeed, we note that CMS itself validated that many of the corrective actions have been taken, and that such corrections were sufficient to remove any immediate jeopardy to the health and safety of MLK-Harbor's patients.

As described in more detail in the attached documents, the corrective actions taken were varied, ranging from training categories of employees in matters such as pain management and documentation, to restructuring the triage process to increase the speed with which patients received a medical screening exam. Importantly, physician assistants were removed completely from patient care roles in the Emergency Department, including urgent care areas, and a process for collecting and trending data on waiting times, including those experienced by psychiatric patients, in the Emergency Department has been initiated.

Although generally correct, the survey findings were inaccurate on a few points and accordingly, corrective actions were not created for certain findings. More particularly, finding 5 under Tag A028, and the identical finding 4 under Tag A156, and under Tag A157, and a related finding under Tag A455, page 53 are factually incorrect. In those findings, the surveyors stated that the hospital failed to take corrective actions after learning of problems transferring Patient #50 who required neurosurgery, because a plan had not yet been implemented. However, by June 7, 2007, the hospital had fully developed and implemented a plan for assuring that these patients would be promptly transferred to either LAC+USC Medical Center or Harbor-UCLA Medical Center on a rotating basis. This plan includes a mechanism to identify and mitigate issues identified with any pending transfers. Evidence reflecting

this can be provided to you on request. Thus, the hospital did satisfy its duty to assure that other patients did not experience the same transfer problems as did Patient #50.[1]

Additionally, we did not provide a response to the findings related to patient #23 under Tag A455 for the reasons discussed in my letter dated June 18, 2007. We believe that the care to this patient was proper.

Finally, we note that the surveyors expressed concerns over staffing in the Emergency Department in light of sometimes extended waiting times. Although a corrective action was developed to address this concern, we want you to be aware that factors other than staffing contribute to waiting times. These include spikes in normal workload, physical space limitations in emergency department treatment areas which have been exacerbated by the reduced number of inpatient beds on site, and the workload of ancillary departments. While these factors are managed and mitigated to the extent possible, some waiting is an unavoidable part of the process of obtaining medical care.

Based on these corrective actions, detailed in the attached materials, MLK-Harbor believes that it has taken sufficient steps to assure that the deficiencies cited as support for CMS' termination decision will not reoccur, and that, following the resurvey which is planned for sometime within the next month, the decision to terminate MLK-Harbor's participation in Medicare may be withdrawn.

If you have any questions about the forgoing, please do not hesitate to contact me.

Very truly yours,

Antionette Smith Epps
Hospital Administrator

Cc: Jacqueline Lincer

1. We note that although the survey findings suggest that the surveyors believed that difficulties were incurred in transferring another patient, Patient #36, who required neurosurgery related to the repair of a malfunctioning shunt, this is not the case. Although a transfer was originally recommended for this patient, further testing revealed that that the shunt was not defective and that the patient's condition stemmed from other causes.

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	050578	A. BUILDING _____ B. WING _____	06/07/2007

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A 000	INITIAL COMMENTS The following reflects the findings of the Department of Heath Services during a complaint survey conducted concurrently with the EMTALA survey of 6/7/07. Representing the Department were Jo Ann Dalby, RN, HFES, Barbara Mellor, RN, HFEN and Sanford Weinstein, MD, Medical Consultant. The original document prepared for the investigation #M80Z11, identified a patient sample size of 60. Eight additional patients were reviewed for this sample size of 68. The original document cited Patients A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P and Q. These patients are cited in this document as using the following identifiers respectively: Patient #50, #69, #36, #26, #5, #6, #7, #66, #67, #68, #63, #64, #65, #2, #23, and #3. Additional patients affected by the hospital's non-compliance with EMTALA requirements were Patient #9, #2, #23, and #3. Additional patients affected by the hospital's non-compliance with Conditions of Participation, for this document include Patient # 9, #49, and #62. At approximately 1530 hours on 6/7/07, hospital administration was notified of an immediate threat to the health and safety of all patients presenting for treatment at the Emergency Department. The hospital failed to: 1. Follow their policies and procedures (P&P), by-laws, rules and regulations developed to ensure medical screening examinations were	A 000	• The hospital filed a response and corrective action plan in connection with the findings of immediate threat to patient health and safety on June 18, 2007. • CMS lifted its termination date based on the corrections described in that document on June 26, 2007.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: A Stephens — TITLE: Administrator — (X6) DATE: 7/10/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 000	Continued From page 1 conducted by appropriately qualified individuals. 2. Ensure on - call physicians saw patients when specialty consultation was required. 3. Ensure pain management was provided in a timely manner 4. Provided stabilizing treatment for emergency medical conditions. 5. Ensure timely transfer of individuals who required services not available at the hospital.	A 000		
A 006	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION is not met as evidenced by: Based on interviews, a review of committee minutes, a review of 68 closed medical records and a review of hospital policies and procedures, the governing body failed to be legally responsible for the conduct of the hospital as a whole. Findings: 1. The governing body failed to ensure that the medical staff, providing direct patient care, was accountable to the governing body for the quality and appropriateness of care being provided to	A 006	**Finding 1:** The Governing Body issued a directive to the medical staff and the Chief Medical Officer to assure that known systemic patient care issues are brought to its attention and placed a member on key committees to assure that the medical staff is accountable to the Governing Body for the quality and appropriateness of care being provided to patients in the ED. See response to Tag A012, pages 4-5 below for additional details.	7/9/07

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A 006	Continued From page 2 patients in the ED. See A0012. 2. The governing body failed to ensure that the medical staff implemented the patient care policies and procedures for the provision of treatment of three psychiatric patients presenting to the emergency department for the evaluation of an emergency medical condition. See A0021. 3. The governing body failed to ensure that emergency department services performed under a contract were provided in a safe and effective manner. The governing body failed to ensure that medical screening examinations being performed in the Emergecny Department were being done by qualified practitioners. See A0028, A0031 and A0452. 4. The governing body failed to ensure that the quality program focused on problem prone, high risk areas of the hospital. Cross reference A0143. 5. The governing body failed to ensure that the quality assurance, performance improvement program correctly identified and set priorities to focus on high-risk, problem prone areas in the hospital. Cross reference A0152. 6. The governing body failed to ensure that the quality assurance program correctly identified and tracked psychiatric emergency patients being managed in violation of the hospital's own rules and regulations and medical staff by laws. Cross reference A0153. 7. The governing body failed to ensure that a written plan had been formalized and implemented to prevent recurrence of adverse	A 006	Finding 2: The Governing Body encouraged and approved the changes to the policies on Management of Psychiatric Patients to assure the proper care of patients with psychiatric problems who present to the ED. See response to Tag A0021 on pages 5-7 below for more detail. Finding 3: The Governing Body has taken corrective actions to assure that ED and other services provided under contract are provided in a safe manner, including approving a Quality Improvement Plan (QI Plan) covering such services, and approving actions to eliminate the use of Physician Assistants in the ED. See Tags A0028, A0031 and A0452 for additional details, pages 7-10 below. Finding 4: The Governing Body approved a new QI Plan which focuses on high risk, problem prone areas of the hospital including the ED. The Governing Body has provided through the approved QI Plan that it will be regularly updated on the operation of the plan and on the status of various quality improvement activities. See Tag A0143 for additional details pages 14-16 below. Finding 5: The Governing Body approved actions to assure that each agenda for a clinical department meeting includes items to review and set priorities for collecting data on problem prone/high risk areas. See A0152 for additional detail pages 16-18 below. Finding 6: The Governing Body approved corrective actions done in furtherance of the quality improvement programs to track and trend data relating to the treatment of psychiatric patients in the ED and to correct policies and practices related to such patients. See Tag A0153 for further details pages 18-21 below. Finding 7: The Governing Body has approved actions to assure that plans to prevent the reoccurrence of adverse patient events are formalized and implemented, including formal plans for transferring neurosurgery	7/9/07 7/9/07 6/21/07 7/6/07 7/9/07 7/9/07

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A 006	Continued From page 3 patient events. Cross reference A0156. 8. The governing body failed to ensure that it had been notified, and had approved the use of uncredentialed PA-Cs, performing medical screening examinations in the main emergency room and the urgent care areas of the emergency department. Cross reference A0167. 9. The governing body failed to ensure that the quality assurance program tracked high risk adverse events to implement a policy to prevent recurrence of these events. Cross reference A0169. The cumulative effects of these systemic problems resulted in the inability of the governing body to ensure the delivery of quality medical care in a safe environment.	A 006	**Finding 8:** The Governing Body assured that it will be notified of relevant patient care issues through the implementation of a new QI Plan which includes regular reporting as well as by placing a representative on key hospital committees. See Tag A0167 pages 26-28 below for additional details. **Finding 9:** The Governing Body approved a new QI Plan. As part of this plan, consideration must be given to properly addressing adverse events. The Governing Body also approved actions to assure that each department includes an evaluation of adverse events in its meetings.	6/21/07 6/21/07 7/9/07
A 012	482.12(a)(5) MEDICAL STAFF - ACCOUNTABILITY The governing body must ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. This STANDARD is not met as evidenced by: Based on interviews, a review of documents provided by the hospital and a review of the closed medical record for Patient # 50, the medical staff failed to be accountable to the governing body for the quality of care provide to each of its patients. Findings: Patient #50 experienced a delay of several days waiting for a higher level of care transfer. This	A 012	**Immediate Action:** The Governing Body, acting through the Director of Health Services, issued a directive to the Interim Chief Medical Officer and the President of the PSA that cases which disclose systemic issues should be included in the reports provided to the Governing Body. (Attachment Z) **Permanent Action:** The monitoring below is designed to assure that the corrective actions remain effective. **Monitoring:** Hospital Administration will review reports to Governing Body to assure that cases raising systemic issues are included. Deficiencies will be addressed with PSA President and Medical Administration. **Responsible Position:** Hospital Administrator	7/9/07

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A 012	Continued From page 4 adverse patient event was reviewed by the medical director of the ED (emergency department) subsequent to the event. The medical director of the ED assessed the quality of care for Patient # 50, as "deemed appropriate." However, this event was evaluated by the risk management committee, who noted that there were no written physician assessments provided for Patient # 50, no attempts at physician to physician contact, and an excessive wait time for the transfer to be completed. Interviews conducted with the Medical Director of the hospital on 06/01/2007 and a review of an administrative document of 03/07/2007 and 03/12/2007, revealed that neurosurgical back up specialty coverage had been scheduled to terminate on 02/28/2007. However, arrangements had been made to extend neurosurgical coverage by "staff surgeons through 04/2007." Thus, back up specialty neurosurgical coverage and intervention by staff surgeons had been provided. Emergency department physicians were unaware that contractural coverage had been extended and was available. The ED physician staff failed to notify the on call neurosurgeon of the presence of Patient #50, who required emergent surgical intervention. There was no written documentation that this finding or sequence of events had been reported to the governing body, the entity with full legal responsibility and oversight for the day to day operation of the hospital. Cross reference A0455.	A 012	**Immediate Actions:** In addition, the Governing Body was made aware of the following actions, which are designed to correct deficiencies and improve quality care. An ad hoc QI committee meeting was held to discuss the cases involving patient #50. There findings were provided to Executive Committee on July 6, 2007. 7/3/07 • The involved physicians were counseled by the ED Medical Director. 6/07 • For ED physicians, the smart chart (a physician documentation record which is a tool used to assure consideration of important clinical questions) was implemented to improve physician documentation and to capture encounter times. 3/07 • The ED Medical Director informed ED physicians at a department meeting and followed up with a written directive that they were responsible for assessing all active patients and patients waiting for transfer at the beginning of each shift. They were also informed of their responsibility to meet with oncoming physicians at the end of shift to provide appropriate information as part of the pass on process. Physicians were also reminded to document all patient's conditions at change of shift and to document that the patient 's care was transferred to the oncoming physician by name (Attachment K). 6/9/07 **Permanent Actions:** The monitoring below is designed to assure that the corrective actions remain effective. **Monitoring:** Ten randomly selected charts will be reviewed each week to validate the documentation of physician involvement at the change of shift. Deficiencies will be addressed by the ED Medical Director. Results of these audits will be provided to the Performance Improvement Committee, which will review and create corrective action as necessary. This data will then be reported to Executive Committee and to the Governing Body as appropriate.
A 021	482.12(c)(4) CARE OF PATIENT A doctor of medicine or osteopathy is responsible	A 021	**Positions Responsible:** ED Medical Director	

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A 021	482.12(c)(4) CARE OF PATIENT A doctor of medicine or osteopathy is responsible	A 021		

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A 021	482.12(c)(4) CARE OF PATIENT A doctor of medicine or osteopathy is responsible	A 021		

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A 021	Continued From page 5 for the care of each Medicare patient with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization; and is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor; or clinical psychologist, as that scope is defined by the medical staff; permitted by State law; and limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors. This STANDARD is not met as evidenced by: Based on a review of documents from the hospital, and a review of closed patient medical records, the governing body failed to ensure that the medical staff implemented patient care policies and procedures for the treatment of four (4) psychiatric patients (Patient #3, #28, #29 and #49) presenting to the emergency department for the evaluation of an emergency medical condition. Findings: 1. Patient #3 came to the emergency department at 2130 hours on 04/30/2007. Patient # 3 was experiencing auditory hallucinations instructing him to drink bleach with the intent of suicide. Patient # 3 was not evaluated by a physician until 0500 hours on 05/01/2007. 2. Patient #28 came to the emergency department with severe depression and was assessed as having suicidal ideation. Patient #28 was logged in to the emergency department log at 2106 hours on 04/28/2007. Patient #28 was instructed to wait in the waiting area until 0015 hours on 04/29/2007, when he was taken to the	A 021	All Findings Immediate Actions: The Governing Body encouraged and approved the medical staff revision of the policy entitled Management of Psychiatric Patients #118 for the Emergency Department was revised to address the needs of psychiatric patients presenting to MLK-H emergency department. The Governing Body approved of the fact that the ED nurse manager completed in-service on the revised policy with emphasis that the patient never be left alone (Attachment W). Permanent Action: Use of the monitoring discussed below will assure that the deficiency remains permanently corrected. The ED nurse manager will provide remedial training when a pattern of deficient practices is determined. Monitoring: The ED Nurse Manager or designee will review ten randomly selected charts each week to assess for appropriateness of triage acuity score based on the Emergency serverity Index, this includes psychiatric patients. The ED Nurse Manager will address deficiencies with responsible individuals. Data from the weekly review will be presented to ED Collaborative Committee which will develop corrective actions. Data will also be presented to the QPIC monthly, which will evaluate it, and report it to the Quality Council and Executive Committee, which will report and to Governing Body. Once audits demonstrate consistency, monitoring will be limited to ten charts monthly. Responsible Position: Chief Nursing Officer ED Nurse Manager	5/29/07

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A 021	Continued From page 6 ED treatment area, the patient's medical screening examination was not initiated until three hours after presenting to the ED. 3. Patient #29 came to the emergency department at 1655 hours on 04/28/2007. Patient #29 was suicidal with a plan and came to the hospital after ingesting an unknown quantity of Elavil, a tricyclic antidepressant medication, known to produce cardiac toxicity in high dosage. Patient #29 was not taken to the treatment area until 1750 hours, and was not evaluated by a physician, until 1800 hours. 4. Patient #49 presented to the emergency department on 3/6/07 at 0302 hours, with a chief complaint of violent behavior, not taking his medications and having auditory hallucinations. The patient had arrived from another local hospital. The patient was triaged by the nurse, assigned a classification of Level III and left in the lobby. The patient was identified as leaving without being seen at 0535 hours. Policy and Procedure #118, Management of Psychiatric Patients, mandates that psychiatric patients with assessed risks for being a danger to self, a danger to others or gravely disabled, must be taken directly to the treatment area to have a medical screening examination. Cross refer to A 028 for failure to ensure patients were under the care of a physician.	A 021	**Background:** Psychiatric evaluations are now provided by the Los Angeles County PMRT personnel because there is no longer an inpatient psychiatric service at this facility. **Immediate Action:** The Psychiatric Transfer Preparation and Management form has been revised and now addresses the documentation status of pending PMRT consultations and inpatient bed placement for patients in the ER. This form includes (Attachment W): • Licensed Nurse will document psych risk assessment at initial assessment and with subsequent reassessment every shift. Assess for: (1) danger to self (2) danger to others (3) identify sitter at bedside by name. Triage: psych patients meeting any of the risk criteria are not to wait in the waiting room. • Sitters (nursing attendant) document interventions and patient's behavior hourly. • Follow-up a minimum of every four hours for the status of the pending PMRT evaluation and bed availability. The licensed nurse will document in the patient's medical record the above status a minimum of every four hours. • Upon discovery a licensed nurse will immediately notify the charge nurse and physician of any elopements or difficulties with placement. • The staff will maintain a daily log book in which they will keep the patient's individual status report.. • Charge Nurse: psych patients will be identified on the daily patient list and faxed to the Department of Health Services mental health liaison. **Permanent Actions:** The monitoring plan set forth below will be used to assure the continuing effectiveness of the corrective actions. The ED nurse manager will address deficiencies with Responsible Positionnel.	5/29/07
A 028	482.12(e)(1) CONTRACTED SERVICES The governing body must ensure that the services performed under a contract are provided in a safe and effective manner.	A 028		

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A 028	482.12(e)(1) CONTRACTED SERVICES The governing body must ensure that the services performed under a contract are provided in a safe and effective manner.	A 028		

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A 028	Continued From page 7 This STANDARD is not met as evidenced by: Based on interviews, a review of selected documents from the hospital and a review of 68 closed patient medical records, the governing body failed to ensure that the services performed under a contract had been provided in a safe and effective manner. Findings: 1. A review of the medical records for 11 of 68 sampled patients selected at random from the emergency department logs, revealed that medical screening examinations were provided by mid level practitioners, PA-Cs, for Patients #5, #7, #9, #15, #62, #63, #64, #65, #66, #67, #68. In addition, the hospital failed to provide prompt medical screening examinations for 11 of 68 sampled patients (Patients #2, #3, #5, #6, #7, #9, #26, #36, #49, #50, #69). 2. A review of the medical staff by-laws, rules and regulations was performed during an onsite investigation at the hospital. These documents did not specify which types of practitioners could provide medical screening examinations in the Emergency Department (ED). There was no documentation delineating such privileges for physician assistants (PA-C) providing medical screening examinations in the emergency department. There was no documentation present in the PA-C privileging forms to assess the qualifications and competence to provide medical screening examinations in the emergency department and/or to determine if an emergency medical condition existed.	A 028	All Findings **Immediate Actions:** With the concurrence of the Governing Body, the Chief Medical Officer notified the ED Medical Director that physician assistants shall no longer perform medical screening examinations (Attachment B). The ED Medical Director informed all physician assistants by e-mail that they may no longer perform medical screening examinations (Attachment C). The Interim Chief Medical Officer also informed the President of the contractor that Physician Assistants were no longer allowed to provide services in the ED. **Permanent Action:** Use of the monitoring discussed below will assure that the deficiency remains permanently corrected. **Monitoring:** Ten randomly selected medical records will be reviewed daily in the ED to validate that medical screening examinations are performed by a physician. The Chief Medical Officer will be notified of discrepancies for immediate corrective actions. Once consistency has been established monitoring will be reduced to quarterly. **Positions Responsible:** ED Medical Director ED Nurse Manager Chief Medical Officer **Finding 2:** We note that the medical staff rules did include adisruption of the practitioners who could perform medical screening examination. (Attachment Y)	6/8/07 6/7/07 6/20/07

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A 028	Continued From page 8 3. Patients #62, #63, #64, #65, #66, #67, #68, were triaged on 5/30 or 5/31/07 and sent to Adult Urgent Care for their medical screening examination and treatment. Each patient had a medical screening examination, treatment and discharge from the ED performed by a PA-C. The patients' medical records revealed they were evaluated, treated and discharged from Adult Urgent Care of the ED prior to the time of supervision or monitoring by the ED physician. The medical record for each patient failed to demonstrate a timed entry by the emergency department physician, as required by a supervising physician. When interviewed on 5/31/07 at approximately 1030 hours, the PA-C stated medical screening examinations in the Adult Urgent Care were provided by the PA-C. The physician made rounds every two hours to sign the patient's medical record, and subsequent to the discharge of the patient. 4. Patients #5, #7, #9 and #15 had their medical screening examination in the main emergency room treatment area. The medical records showed the exams were performed by PA-Cs. There were no timed co-signatures of the records by a supervising physician. Interviews conducted with administrative staff revealed that medical care in the ED was being provided by a recently contracted group of physicians specializing in emergency medicine. It was further stated that the physician assistants working in the emergency care areas were part of the ED group. Cross refer to A455 for failure to provide prompt medical screening evaluations for Patients #2, #3,	A 028		

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A 028	Continued From page 9 #5, #6, #7, #9, #26, #36, #49, #50, and #69. 5.. The physician contract to provide neurosurgical coverage to the hospital expired on 4/30/07. The governing body meeting minutes documented a continuing need for this coverage and a plan to provide this. However, as of 6/7/07, this plan had not been implemented to prevent patient safety issues.	A 028	The Chief Medical Officer notified the ED Medical Director that Physician Assistants shall no longer perform medical screening examinations (Attachment B)	6/8/07
			The ED Medical Director informed all Physicians by e-mail that they may no longer perform medical screening examinations (Attachment B)	6/7/07
			Permanent Actions: The monitor plan set forth below will be used to assure the continuing effectiveness of the corrective actions.	
A 031	482.12(f)(1) EMERGENCY SERVICES If emergency services are provided at the hospital, the hospital must comply with the requirements of §482.55. This STANDARD is not met as evidenced by: Based on interviews, a review of 68 closed medical records and a review of documents from the hospital, the governing body failed to ensure that emergency services provided at the hospital met the requirements of section 482.55. Findings: 1. The hospital failed to ensure the immediate availability of services, qualified personnel and other hospital departmental services to provide prompt evaluation and treatment of patients presenting to the emergency department. Cross reference to A0028 and A0452. 2. The hospital failed to follow their policies and procedures (P&P), by-laws, rules and regulations developed to ensure medical screening examinations were conducted by appropriately qualified individuals. The hospital failed to ensure that the policies and procedures for evaluating	A 031	**Monitoring:** Ten randomly selected medical records will be reviewed daily to track the time from triage to medical screening examination. Data from these daily reviews will be presented to the ED Collaborative Practice Committee and the process will be re-evaluated as a result of this review. Data will also be presented to the Performance Improvement Committee monthly, which will evaluate it, develop corrective actions as necessary, and report it to the Executive Committee and as appropriate to the Governing Body. Once the process is stable, the daily record review will convert to a monthly review. **Positions Responsible:** ED Medical Director ED Nurse Manager Interim Chief Medical Officer There is no longer an inpatient service at this facility. Psychiatric patients re triaged in the ED, undergo a medical screening examination and are medically cleared prior to contacting the Psychiatric Medical Response Team (PMRT). The Psychiatric Transfer Preparation and Management form has been revised and now addresses the documentation status of pending PMRT consultations and inpatient bed placement for patients in the ER. This form includes (Attachment W)	

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A 031	482.12(f)(1) EMERGENCY SERVICES If emergency services are provided at the hospital, the hospital must comply with the requirements of §482.55. This STANDARD is not met as evidenced by: Based on interviews, a review of 68 closed medical records and a review of documents from the hospital, the governing body failed to ensure that emergency services provided at the hospital met the requirements of section 482.55. Findings: 1. The hospital failed to ensure the immediate availability of services, qualified personnel and other hospital departmental services to provide prompt evaluation and treatment of patients presenting to the emergency department. Cross reference to A0028 and A0452. 2. The hospital failed to follow their policies and procedures (P&P), by-laws, rules and regulations developed to ensure medical screening examinations were conducted by appropriately qualified individuals. The hospital failed to ensure that the policies and procedures for evaluating	A 031	• Upon discovery a licensed nurse will immediately notify the charge nurse and physician of any elopements or difficulties with placement. • The staff will maintain a daily log book in which they will keep the patient's individual status report. Once psychiatric report log sheet is used for one patient within a 24 hours period. • The above log will be kept in the ED in a binder labeled Psychiatric Patient-Daily Log. • Charge Nurse: psych patients will be identified on the daily patient list and faxed to the Department of Health Services mental health liaison. **Permanent Actions:** The monitoring plan set forth below will be used to assure the continuing effectiveness of the corrective actions. The ED nurse manager will address deficiencies with responsible personnel. **Monitoring:** The log book will be reviewed weekly to identify any deficiencies and take corrective action as deemed necessary. The ED Collaborative Committee will review the data monthly Quarterly the QPIC will evaluate the data, create corrective action as needed and report to Quality Council and Executive Committee and, as appropriate, Governing Body. **Position Responsible:** ED Nurse Manager	

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A 031	482.12(f)(1) EMERGENCY SERVICES If emergency services are provided at the hospital, the hospital must comply with the requirements of §482.55. This STANDARD is not met as evidenced by: Based on interviews, a review of 68 closed medical records and a review of documents from the hospital, the governing body failed to ensure that emergency services provided at the hospital met the requirements of section 482.55. Findings: 1. The hospital failed to ensure the immediate availability of services, qualified personnel and other hospital departmental services to provide prompt evaluation and treatment of patients presenting to the emergency department. Cross reference to A0028 and A0452. 2. The hospital failed to follow their policies and procedures (P&P), by-laws, rules and regulations developed to ensure medical screening examinations were conducted by appropriately qualified individuals. The hospital failed to ensure that the policies and procedures for evaluating	A 031		

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A 031	482.12(f)(1) EMERGENCY SERVICES If emergency services are provided at the hospital, the hospital must comply with the requirements of §482.55. This STANDARD is not met as evidenced by: Based on interviews, a review of 68 closed medical records and a review of documents from the hospital, the governing body failed to ensure that emergency services provided at the hospital met the requirements of section 482.55. Findings: 1. The hospital failed to ensure the immediate availability of services, qualified personnel and other hospital departmental services to provide prompt evaluation and treatment of patients presenting to the emergency department. Cross reference to A0028 and A0452. 2. The hospital failed to follow their policies and procedures (P&P), by-laws, rules and regulations developed to ensure medical screening examinations were conducted by appropriately qualified individuals. The hospital failed to ensure that the policies and procedures for evaluating	A 031		

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A 031	Continued From page 10 psychiatric emergency patients had been implemented and followed by staff. Cross reference to A0021. 3. The hospital failed to ensure on - call physicians saw patients when specialty consultation was required. Cross reference to A00 4. The hospital failed to ensure pain management was provided in a timely manner. Cross reference to A0204, A0455 5. The hospital failed to ensure stabilizing treatment for emergency medical conditions was provided and failed to ensure timely transfer of individuals who required services not available at the hospital. Cross reference to A	A 031	Finding 3 **Immediate Actions:** • The Interim Chief Medical Officer ordered all MLK Department Chiefs to discontinue the practice of using Physician Assistants for consultations in the ED. All ED consultations will be performed by an attending physician. (Attachment X) • The ED nurse manager provider a letter instructing all ED RNs regarding Physician Assistants cannot provide consults. (Attachment J) • The Interim Chief Medical Officer instructed all Department Chiefs to ensure that all attending physicians are aware of the need to document their consultations. • The Interim Chief Medical Officer instructed all physicians that provide consults to patients that emergency consultations are to be seen within one hour.	6/15/07 6/19/07 6/18/07 7/5/07
A 141	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.	A 141	**Permanent Actions:** The monitoring plan set forth below will be used to assure the continuing effectiveness of the corrective actions. **Monitoring:** Ten randomly selected ED records of patients will be reviewed each week to validate the presence of the at note and timeliness of the consult. Results of these audits will be presented to Performance Improvement Committee, which will review and create corrective actions a necessary. This data will then be reported to the Executive Committee and to the Governing Body as appropriate. The Chair of the service will be notified of discrepancies for corrective actions. **Position Responsible:** Chief Medical Officer	

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A 031	Continued From page 10 psychiatric emergency patients had been implemented and followed by staff. Cross reference to A0021. 3. The hospital failed to ensure on - call physicians saw patients when specialty consultation was required. Cross reference to A00 4. The hospital failed to ensure pain management was provided in a timely manner. Cross reference to A0204, A0455 5. The hospital failed to ensure stabilizing treatment for emergency medical conditions was provided and failed to ensure timely transfer of individuals who required services not available at the hospital. Cross reference to A	A 031	Finding 4 Immediate Actions: A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triage policy was revised so that the triage registered nurse notifies the medical provided if the patient is experiencing pain greater than 7/10 and follows physician's order to initiate pain medication for pain relief regardless of triage acuity level.	6/21/07
A 141	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.	A 141	Immediate Actions: The ED Nurse Manager and a nurse educator provided supplemental training to all ED RN staff on the importance of contacting physicians and the need to be a patient advocate. The ED Nurse Manager counseled the ED nurse for failing to document notification of the physician when a change in condition was noted. The ED Nurse Manager counseled the RN who failed to record the attributes of pain as required by policy. The ED Nurse Manager conducted inservice training for all ED RNs regarding appropriate documentation of pain assessments and the requirements for reassessment after medication administration. Training was also provided on documentation standards. (Attachment N) Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED nurse manager will address deficiencies with responsible personnel.	6/5/07 7/9/07 6/19/07 6/6/07

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A 141	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.	A 141		

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A 141	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.	A 141	**Permanent Action:** The monitoring plan set forth below will be used to assure the continuing effectiveness of corrective actions. The Patient Flow Manager will report deficiencies as identified for remedial training. **Monitoring:** The Patient Flow Manager maintains a log of patient transfers. Data regarding patient transfers is aggregated and presented to Performance Improvement Committee and to the Executive Committee, and then to the Governing Body where appropriate. **Position Responsible:** Interim Chief Medical Officer	

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A 141	Continued From page 11 This CONDITION is not met as evidenced by: Based on interviews, a review of documents supplied by the hospital, a review of minutes from committees of the hospital and review of 68 closed medical records, the governing body of the hospital failed to ensure an effective quality performance improvement program that focused on high risk areas and contractural arrangements being provided to the patients presenting for the evaluation of an emergency medical condition. Findings: 1. The governing body failed to ensure that the quality program focused on problem prone, high risk areas of the hospital. The quality assurance program failed to track and trend the emergency department waiting times and to identify incorrect log in times for emergency department patients. The quality program failed to identify that multiple logs were being utilized in the hospital that failed to present an accurate representation of patients presenting for the evaluation of an emergency medical condition. Cross reference A0143 and A0405. 2. The governing body failed to ensure that the quality assurance, performance improvement program correctly identified and set priorities to focus on high-risk, problem prone areas in the hospital. The governing body failed to ensure that the quality assurance program had identified that PA-Cs were either initiating or providing formal back up specialty consultations in the emergency department. The governing body failed to ensure that the quality assurance program had identified and tracked a patient presenting with a malfunctioning shunt in the pediatric outpatient area, in which the management of the patient was	A 141	Finding 1: 1) On 6/11/07, the Quality Council developed a Quality Improvement Plan that focuses on problem prone, high risk areas. Recognizing that the ED is such an area, unique quality indicators and special monitoring for that area has been established. (Attachment A) 2) Starting July 1, 2007, Utilization Review Staff will review at least 15% of patients weekly to track and trend data from arrival to triage and arrival to medical screening exam. Time of arrival to time of discharge is tracked electronically through the Affinity System for all patients and trended weekly. The information goes to the Emergency Department Collaborative Committee for evaluation. The reports will go to both the ED Committee and the Quality/Performance Improvement Committee (QPIC), which will report this to the Executive Committee or Quality Council respectively, and then to the Governing Body. 3) Process were changed to assure the accuracy of the log and to combine the multiple log into a single document ordered in date time sequence. See Tag A143 below, page 15 for more details. Finding 2: Under instructions from the Governing Body, a new QI Plan was developed and implemented. In the new QI plan, hospital-wide, department specific indicators for problem prone, high risk areas have been developed. These indicators specifically look at consults in the ED. Please see tag (Attachment A) below for more information	6/21/07

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A 141	Continued From page 12 being provided by a PA-C. Cross reference A0152. 3. The governing body failed to ensure that the quality assurance program correctly identified and tracked psychiatric emergency patients being managed in violation of the hospital's own rules and regulations and medical staff by laws. Cross reference A0153. 4. The governing body failed to ensure that a written plan had been formalized and implemented to prevent recurrence of adverse patient events. Cross reference A0156. 5. The governing body failed to ensure that the quality assurance program had informed the governing body that PA-Cs were performing medical screening examinations in the main emergency room and the urgent care areas of the emergency department. The governing body failed to ensure that the quality assurance program had identified that these mid level practitioners were not credentialed to perform a medical screening examination. Cross reference A0167. 6. The governing body failed to implement a policy to prevent recurrence of these events. Cross reference A0169. The cumulative effects of these systemic problems resulted in the inability of the governing body to ensure that the Quality Assurance, Performance Improvement program had tracked and identified high risk, problem prone areas in the hospital to ensure the provision of medical care in a safe environment.	A 141	Finding 3: • Psychiatric process improvements including improved triage training, better documentation by "sitters" in the area, and better flow management have been implemented. Please see Tag A0153 below for more information. • Psychiatric patients are included on monitoring tracking and trending of wait times of all ED patients. • The Interim Medical Director ED shall include a discussion of any psychiatric care issues and determine whether additional QI indicators are required to address them. Finding 4: • A neurosurgery policy was formalized and distributed to all Department Chairs who were instructed to inform their staff about it. (Attachment I) 6/15/07 • The Interim Chief Medical Officer on instructions from the Governing Body, has emphasized at each department's meeting that all corrective actions have to be promptly established in writing and implemented. He further emphasized that each department must monitor such implementation. • The QI Plan was created to include formal quality indicators, both hospital wide and ED specific, which under the terms of the plan will lead to corrective actions, which will prevent the recurrence of adverse events. For a more detailed response see Tag A156 below. Finding 5: • Physician Assistants are no longer providing medical screening examinations. See Tag A028, page 8 for more details. • The Governing Body has instructed a delegate to attend Quality Council and Executive Committee meetings to ensure that it is informed of quality and compliance issues. (Attachment Z) Finding 6: • On 6/11/07, the Quality Council developed a QI Plan that focuses on problem prone, high risk areas of the hospital and is designed to reduce medical errors and improve patient care. The new QI Plan was reviewed and approved by the Executive Committee: the Governing Body reviewed and approved the plan on 6/29/07. Under the approved QI Plan data collected from all hospital departments including Information Systems and Emergency Services is reported to the QPIC. Monthly the QPIC	
A 143	482.21(a)(1) QAPI HEALTH OUTCOMES	A 143		

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A 143	Continued From page 13 The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes. This STANDARD is not met as evidenced by: Based on interviews, a review of closed patient records and a review of meeting minutes from the hospital, the hospital failed to ensure an ongoing program that accurately measured patient length of stay in the emergency department. Findings: 1. Interviews with the Medical Director of the ED and with the quality improvement representatives from the hospital were conducted on 6/01/2007 at approximately 1350 hours. The wait times in the ED were discussed. It was revealed that the average time for a patient to complete evaluation and treatment in the emergency department was approximately 14 hours. The Medical Director of the ED stated that length of stay in the ED was very difficult to track. The ED Medical Director stated that she was unaware of the method being used by the ED Nurse Manager to collect data regarding the patient length of stay. The ED Medical Director stated that she had recently initiated a study to track door to provider time and bed to provider time. This data had been entered on a grid and that 10 charts were selected from a cohort of 140-150 patients per day case load. The plan to collect data, track and trend patient length of stay in the ED had not been developed and the ED Director failed to produce documentation of the data or the plan for hospital wide QA when	A 143	Background: Miscommunication appears to have occurred as the ED has been collecting data on ED length of stay, on a limited scope basis since January 2007, and has shared that data with the Physician Performance Improvement Committee. Immediate Actions: Starting July 1, 2007, Utilization Review Staff will review at least 15% of patients weekly to track and trend data from arrival to triage and arrival to medical screening exam. Time of arrival to time of discharge is tracked electronically through the Affinity System for all patients and trended weekly. The information goes to the Emergency Department Collaborative Committee for evaluation. The reports will go to both the ED Committee and the Quality/Performance Improvement Committee (QPIC), which will report this to the Executive Committee or Quality Council respectively, and then to the Governing Body. Permanent Actions: Use of the monitoring below will assure that the deficiency remains corrected. The QI Director will provide remedial training where a pattern of deficient practices is determined. Monitoring : The Director of Quality Improvement or her designee will use a checklist every two weeks for the first three months and then monthly thereafter, to assure that data collection and trending is occurring. Deficiencies will be addressed immediately with the responsible supervisor. Summaries of her findings will be forwarded to the QPIC quarterly. Responsible Position: QI Director	

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A 143	Continued From page 14 requested. There was no written documentation that this plan had been approved by the QAPI committee to ensure that data accumulation was accurate and reflected patient care outcomes. 2. During interviews conducted on 06/01/2007, the quality improvement representatives were unaware, that for some patients, the ED log in times were inaccurate and failed to accurately reflect the correct time of entry of the emergency department patient for evaluation of an emergency medical condition. Patient #14 came to the emergency department on 01/26/2007. The time of entry in the computer log read "1324 hours." However, Patient #14 actually was was seen in triage at 1224 hours. Patient #5 was logged into the ED log at 1510 hours on 05/11/2007. The medical record revealed that Patient #5 had actually been assessed by the triage nurse three hours earlier, at 1139 hours on 05/11/2007. The medical record for Patient #6 showed he presented to the ED for triage at 1812 hours on 5/11/07 and left without being seen for a medical screening exam. He was not logged into the ED log until 1913 hours and the log failed to identify that he left without being seen. 3. During interviews conducted on 06/01/2007, the quality improvement representatives were unaware that a "Central Log" for the emergency department failed to contain the names of all patients presenting to the facility for evaluation of an emergency medical condition. The information technology representative revealed that the "emergency department log" contained only those patients evaluated in the main emergency room. Separate patient logs existed for ED patients seen in the Adult Urgent Care area and a separate log existed for the Pediatric Outpatient	A 143	Finding 2 **Immediate Actions:** A multidisciplinary group reviewed and revised emergency registration/admitting policy #1.1.32 entitled Registration and Financial Screening to require that original time of arrival be entered into the computerized central log must be congruent with the nursing flow sheet. **Permanent Actions:** The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The QI Director will address deficiencies with responsible personnel. **Monitoring:** Beginning 7/1/2007 PFS personnel weekly review the central EMTALA log weekly. Average wait times from triage to medical screening examination and triage to discharge that exceed expectations will prompt a medical record review, the central log will be reconciled for inconsistencies with the medical record. The HIM Director will report on the accuracy of data collection quarterly to QPIC. **Responsible Position:** QI Director **Immediate Actions:** 1) The Director of Quality Improvement retrained all staff on the distinction between central log and working logs and their use. 2) IT re-programmed the central log to default to display or print in date time sequence regardless of triage location. **Permanent Actions:** Use of the monitoring below will assure that the deficiency remains corrected. The HIM director will provide remedial training where a pattern of deficient practices is determined.	6/14/07

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A 143	Continued From page 15 department. It was revealed that a complete log for all patients was known as the "EMTALA" log and this log contained all adult, pediatric and urgent care patients. When produced, the EMTALA log was not in chronological order. The IT representative stated that separate logs existed for "Patient Transfers" and "Labor and Delivery."	A 143	Monitoring: PFS personnel will review the central EMTALA log monthly to verify that all patients regardless of treatment location (emergency department, adult urgent care, or pediatric urgent care) will appear in chronological date/time order of when the patient presented in the ED. Deficiencies will be reported to the HIM Director for corrective action. The need for further corrective action will be reported to the QPIC as appropriate. Responsible Position: HIM Director	
A 152	482.21(c)(1)(i-iii) QAPI IMPROVEMENT PRIORITIES The hospital must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes and quality of care; This STANDARD is not met as evidenced by: Based on interviews, a tour of the ED service areas, a review of documents supplied by the hospital and review of 68 patient records, the hospital failed to ensure that its performance improvement activities identified and focused on high-risk, high-volume, or problem-prone areas. The quality improvement program failed to consider the incidence, prevalence, and severity of problems in those areas. Findings: 1. A tour of the ED service area and interviews with the ED Medical Director and an ED Staff Physician were conducted on 05/31/2007. They stated that two ED physicians were scheduled in the ED at all times, except for two hours at	A 152	Immediate Actions: • The hospital has developed a new QI Plan, which includes specific, targeted indicators for the ED. Priorities for projects are established in the ED plan. (Attachment A) • The Interim Medical Director has instructed all departments to assure that each department meeting includes a review of the indicators being tracked to determine whether the most significant high risk areas are being tracked and trended, and to gather data so that an evaluation based on incidence and prevalence and severity of the most important problems can be made.	

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A 152	Continued From page 16 mid-day, when a third physician assumed patient care responsibilities for the out-going ED physician. When interviewed, the ED Medical Director stated that physician staffing was sufficient to provide adequate patient care in the ED. When asked if one physician was sufficient to provide coverage for the main ED, in the event of a trauma case, requiring one physician in the trauma room, the ED Director stated that coverage was sufficient to provide supervision of the main ER, the urgent care areas and supervision of the triage and patient waiting areas. On 06/01/2007, during a QAPI committee interview, the ED Medical Director identified the average length of stay in the ED was 14 hours. There was no documented evidence provided for a plan to evaluate the time required to see a physician following placement of a patient in the treatment area. There was no documentation for a plan to evaluate Triage staffing to determine the time before nurse evaluation of a patient. 2.a. A tour of the ED service areas were conducted at approximately 1030 hours on May 31, 2007. It was learned that physician assistants(PA-Cs) had been initiating formal specialty back up consultations in the emergency department. It was also learned that physician assistants had been providing patient care in the urgent care clinic of the hospital. When interviewed, physician representatives initially disclosed that PA-Cs did not perform consultations in the emergency department. However, further discussions revealed that consultations were only initiated by PA-Cs. The back up specialist on call came to provide the full consultation. However, a review of the closed	A 152	Finding 1 **Immediate Action:** As noted above an organized system to track and trend wait times between various steps in the ED has been created. When sufficient data has been gathered, the ED Collaborative Committee and nursing will evaluate the adequacy of triage staffing. **Permanent Action:** The Chief Medical Officer will assure that the adequacy of triage staffing is periodically addressed in light of relevant data. **Monitoring:** Director of Quality Improvement will review meeting minutes to determine if matter was reviewed. Deficiencies will be brought to Chief Medical Officer's attention. Finding 2A **Immediate Actions:** In the new QI Plan, hospital wide and department specific indicators for problem prone, high risk areas have been developed. These indicators include a review of consults and who is performing these consults. **Permanent Actions:** The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The chair of the relevant consulting department will address with responsible personnel deficiencies. **Monitoring:** For the next 30 days, Monday through Friday, UR RNs will review ten randomly selected open medical records in the ED to validate that consults were performed by a physician and that there is a consulting physician's note and that the consultation was timely. The Chair of the relevant department will be notified of discrepancies for immediate corrective action. Deficiencies will be reported to the Physician Performance Improvement Committee after practices become compliant, ~~monitoring will be reduced to monthly.~~	

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A 152	Continued From page 17 record for Patient #50 revealed that a PA-C wrote the formal consultation for this patient. This consultation was signed by the consultant approximately one and one-half hours later. There was no written note provided by the consultant to verify or document the accuracy of the findings described by the PA-C or to document a neurological evaluation for Patient #50. 2. b. Patient #36 presented to the emergency department at 1030 hours on 3/20/07 for vomiting, lethargy, cough and congestion. Documentation indicated a shunt malformation and/or infection. A neurology consult was ordered. At 1230 hours, the physician's assistant was summoned to provide neurological consultation. The PA-C saw the patient to perform the neurology consultation without the presence of a physician. The PA-C documented the recommended plan, in consultation with the neurologist, would be evaluation and management by a neurosurgeon on an urgent basis to assess the functioning of the shunt. Since neurosurgeons were not available at the hospital the PA recommended transfer to another hospital. The child was in the emergency department until 2200 hours but there was no documented evidence a neurosurgeon was contacted or that efforts were made to transfer the patient to a hospital with this service available. The patient was discharged to the mother's care. Cross reference A0455	A 152	Finding 2B **Immediate Actions:** In the new QI Plan, hospital wide and department specific indicators for problem prone, high risk areas have been developed. These indicators include a review of consults and who is performing these consults. **Permanent Actions:** The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The chair of the relevant consulting department will address with responsible personnel deficiencies. **Monitoring:** For the next 30 days, Monday through Friday, UR RNs will review ten randomly selected open medical records in the ED to validate that consults were performed by a physician and that there is a consulting physician's note and that the consultation was timely. The Chair of the relevant department will be notified of discrepancies for immediate corrective action. Deficiencies will be reported to the Physician Performance Improvement Committee relevant department will be notified of discrepancies for immediate corrective action. Deficiencies will be reported to the Physician Performance Improvement Committee and to the Quality Council and Executive Committee and Governing Body as appropriate. After practices become compliant, monitoring will be reduced to monthly. **Responsible Persons:** Medical Director ED Medical Director QI Director	
A 153	482.21(c)(1)(iv) QAPI PATIENT SAFETY The hospital must set priorities for its performance improvement activities that affect patient safety.	A 153		

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A 153	Continued From page 18 This STANDARD is not met as evidenced by: Based on interviews and a review of the minutes of quality assessment and performance improvement committee minutes, the hospital failed to ensure that high risk, problem prone patient care issues for Patients #3, #28, #29, #49, #50, and #36, had been identified and tracked to ensure patient safety. Findings: Policy and Procedure #118, mandates that the management of psychiatric patients assessed as being a danger to self, a danger to others or gravely disabled must be taken directly to the treatment area to have a medical screening examination. 1. Patient # 3 came to the emergency department of the hospital at 2130 hours on 04/30/2007. Patient # 3 was experiencing auditory hallucinations instructing him to drink bleach with the intent of suicide. Patient # 3 was not evaluated by a physician until 0500 hours on 05/01/2007 Patient # 28 came to the emergency department with severe depression and was assessed as having suicidal ideation. Patient #28 was logged in to the emergency department log at 2106 hours on 04/28/2007. Patient #28 was instructed to wait in the waiting area until 0015 hours on 04/29/2007, three hours after arrival in the ER, when he was taken to the treatment area of the hospital.	A 153	Finding 4 Immediate Actions: Under instructions from the Governing Body, a new QI Plan was developed and implemented. In the new QI plan, hospital-wide, department specific indicators for problem prone, high risk areas have been developed. (Attachment A) Starting July 1, 2007, Utilization Review Staff will review at least 15% of patients weekly to track and trend data from arrival to triage and arrival to medical screening exam. Time of arrival to time of discharge is tracked electronically through the Affinity System for all patients and trended weekly. Psychiatric patients are included in the data. The information goes to the Emergency Department Collaborative Committee for evaluation. The reports will go to both the ED Committee and the Quality/Performance Improvement Committee (QPIC), which will report this to the Executive Committee or Quality Council respectively, and then to the Governing Body. The ED Collaborative Committee will consider periodically whether special studies are required with respect to psychiatric patients. If so, it will develop plans for such studies and forward memo to QPIC for approval. Permanent Actions: Use of the monitoring below will assure that the deficiency remains corrected. The QI Director will provide remedial training where a pattern of deficient practices is determined. Monitoring: Monitoring on data collection will be done by the Director of Quality or her designee, will use a checklist every two weeks for three months and then monthly thereafter to assure that data collection and trending is occurring. Deficiencies will be addressed immediately with the responsible supervisor. Summaries of findings will be forwarded to QPIC quarterly. Monitoring of ED consideration of psychiatric specific indicators will be done by the ED Medical Director through Department minutes. Position Responsible: ED Medical Director QI Director	

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A 153	Continued From page 19 Patient #29 came to the emergency department of the hospital at 1655 hours on 04/28/2007. Patient #29 was suicidal with a plan and came to the hospital after ingesting an unknown quantity of Elavil, a tricyclic antidepressant medication, known to produce cardiac toxicity in high dosage. Patient #29 was not taken to the treatment area of the emergency department until 1750, and not evaluated by a physician until 1800 hours. Patient #49, presented to the emergency department at on 3/6/07 at 0302 hours, with a chief complaint of violent behavior, not taking his medications and was experiencing auditory hallucinations. The patient had arrived from another hospital. the patient was identified as having left without being seen at 0535 hours. There was no documentation to indicate that a QAPI study for data accumulation had been implemented to evaluate patient wait times for psychiatric emergency patients requiring urgent evaluation. 2. Patient # 50 came to the hospital on 02/28/2007 for the evaluation of a neurosurgical emergency. Patient #50 experienced a delay of several days waiting for a higher level of care transfer. This adverse patient event was reviewed by the medical director of the emergency department subsequent to the event. The medical director of the emergency department assessed the quality of care for Patient # 50 as " deemed appropriate ". However, this event was evaluated by the risk management committee that noted that there were no written physician assessments provided for Patient # 50, no attempts at physician to physician contact, and an excessive wait time for	A 153	Finding 2 Immediate Actions: In addition to the Patient Safety Network (PSN) operated at a DHS level which allows reporting of Patient Safety issues, a QI nurse has been assigned to each department. Her function is to assess quality and to determine whether instances which could compromise patient care have occurred. These cases are brought to the attention of the Department Chair and nursing leadership, as appropriate. If the Chair or nursing leadership believe it necessary, the case is reviewed in detail and then reported at the Department meeting. A decision is then made whether new indicators should be added to the Department's quality improvement activities. Permanent Actions: Use of the monitoring below will assure that the deficiency remains corrected. The QI director will provide remedial training where a pattern of deficient practices is determined.	

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A 153	Continued From page 20 the transfer to be completed. There was no documented evidence to indicate that the hospital evaluated this incident for performance improvement to prevent a recurrence for a similar event. When interviewed on 06/01/2007, the CEO of the hospital was unable to say if any other cases of this nature had occurred. (Cross reference A0455). 3. Patient #36 presented to the emergency department at 1030 hours on 3/20/07 with a presenting complaint of vomiting, lethargy, cough and congestion. Patient # 36 had a ventriculoperitoneal shunt placed for the treatment of hydrocephalus. Symptoms appeared following a visit to the dentist. Shunt malformation and/or infection was being suspected. A neurology consult was ordered. At 1230 hours, a PA-C came to the pediatric area to assess the patient and perform the neurology consultation. The back up specialist on call list revealed that a neurologist was on call for the ED. There was no documented evidence a neurologist came to see the patient; however, the PA-C documented that the recommended plan, in consultation with the neurologist, was for evaluation and management by a neurosurgeon on an urgent basis to assess the shunt. Since neurosurgeons were not available at the hospital the PA-C recommended transfer to another hospital. The child was in the emergency department until 2200 hours but there was no documented evidence a neurosurgeon was contacted, or that efforts were made to transfer the patient to a hospital with this service available. The patient was discharged to the mother's care with instruction for the child to be seen at the neurosurgery clinic.	A 153	**Monitoring:** QPIC will review the level of data regarding review of potentially problematic cases received from the Departments and the quality of the review of the cases being done. Deficiencies will be addressed with Departments as appropriate. Critical findings from this process are forwarded to Executive Committee or Quality Council as appropriate, which shall report to the Governing Body. **Responsible Position:** QI Director Finding 3 **Immediate Actions:** In addition to the Patient Safety Network (PSN) operated at a DHS level which allows reporting of Patient Safety issues, a QI nurse has been assigned to each department. Her function is to assess quality and to determine whether instances which could compromise patient care have occurred. These cases are brought to the attention of the Department Chair and nursing leadership, as appropriate. If the Chair or nursing leadership believe it necessary, the case is reviewed in detail and then reported at the Department meeting. A decision is then made whether new indicators should be added to the Department's quality improvement activities. **Permanent Actions:** Use of the monitoring below will assure that the deficiency remains corrected. The QI director will provide remedial training where a pattern of deficient practices is determined. **Monitoring:** QPIC will review the level of data regarding review of potentially problematic cases received from the Departments and the quality of the review of the cases being done. Deficiencies will be addressed with Departments as appropriate. Critical findings from this process are forwarded to Executive Committee or Quality Council as appropriate, which shall report to the Governing Body. **Responsible Position:** QI Director	
A 156	482.21(c)(2) QAPI FEEDBACK AND LEARNING	A 156		

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A 156	Continued From page 21 Performance improvement activities must implement preventive actions and mechanisms that include feedback and learning throughout the hospital. This STANDARD is not met as evidenced by: Based on interviews, a review of hospital documents and a review of minutes of the quality assessment and performance improvement committee, the hospital failed to ensure performance improvement activities implemented preventative actions and mechanisms to ensure that patients (#50 and #36)received requested neurosurgical consults by providing that on call specialty. In addition, the hospital failed to ensure that medical screening examinations were provided by qualified staff, unsupervised by the medical staff to Patients #62, #63, #64, #65, #66 and #67. Findings: 1. Patient # 50 came to the hospital on 02/28/2007 for the evaluation of a neurosurgical emergency. A neurosurgeon was actually on call to provide back up specialty consultation. However, the ED physician failed to contact the on-call physician. Patient #50 experienced a delay of several days waiting for a higher level of care transfer. This adverse patient event was reviewed by the medical director of the emergency department subsequent to the event. The medical director of the emergency department assessed the quality of care for Patient #50 as "deemed appropriate." However, when this event was evaluated by the risk management committee it was noted that there were no written physician assessments provided for Patient	A 156	Finding 1 and 2 Immediate Actions: The Interim Chief Medical Officer sent a memorandum to all clinical services instructing them to assure that all staff are informed whenever a change in the scope of clinical services available at the hospital occurs. (Attachment V)	7/9/07

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A 156	Continued From page 22 #50, no attempts at physician to physician contact to expedite a transfer, and an excessive wait time for the transfer to be completed. Interviews conducted with the Medical Director of the hospital on 06/01/2007 and a review of an administrative document of 03/07/2007 and 03/12/2007, revealed that neurosurgical back up specialty coverage had been scheduled to terminate on 02/28/2007. However, arrangements had been made to extend neurosurgical coverage by staff neurosurgeons "through 04/2007" Medical staff interviews revealed that the Emergency Department physicians were not informed that contractural coverage had been extended and available. 2. Patient #36 presented to the emergency department at 1030 hours on 3/20/07, with a presenting complaint of vomiting, lethargy, cough and congestion. Patient # 36 had a ventriculoperitoneal shunt placed for the treatment of hydrocephalus. Shunt malformation and/or infection was being suspected. A neurology consult was ordered. At 1230 hours, a PA-C came to the pediatric area to assess the patient and perform the neurology consultation. The back up specialist on call list, revealed that a neurologist was on call for the ED. There was no documented evidence a neurologist came to see the patient; however, the PA-C documented that the recommended plan, in consultation with the neurologist, was for evaluation and management by a neurosurgeon on an urgent basis to assess the shunt. A neurosurgeon was on call to provide consultation in the ED; however, there was no evidence the physician was called to provide	A 156	Neurology was not an appropriate consult in this case and ultimately a neurosurgery consult was determined not to be necessary because further testing revealed no shunt malfunction. Nevertheless to assure that all staff are aware of the scope of clinical care available at the hospital, the Interim Chief Medical Officer has instructed all clinical departments to assure that all staff are informed whenever a change in the scope of clinical services available at the hospital occurs. Permanent Action: Use of the monitoring below will assure that the deficiency remains corrected. The Chief Medical Officer will take action if different practices are identified. Monitoring: Information regarding changes in the scope of clinical services is provided to the Chief Medical Officer who will verify a notification memo has been distributed hospital-wide. Responsible Position: Chief Medical Officer	

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A 156	Continued From page 23 consultation. Since neurosurgeons were thought to not be available at the hospital, the PA-C recommended transfer to a hospital with neurosurgical coverage. The child was in the emergency department until 2200 hours, but there was no documented evidence a neurosurgeon was contacted, or that efforts were made to transfer the patient to a hospital with this service available. The patient was discharged to the mother's care with instruction for the child to be seen at the neurosurgery clinic. When interviewed on 06/01/2007 at approximately 1400 hours, the quality assurance committee, the medical director of the hospital, the medical director of the emergency department and the CEO of the hospital were unable to determine if a similar neurosurgical events had occurred. When requested, the hospital was unable to provide documentation that a written plan had been implemented by the quality assessment, performance improvement committee to identify, track or prevent similar subsequent adverse patient events. 3. When interviewed at approximately 1630 hours on 6/1/2007, the Hospital Administrator for Los Angeles County, and representative of the governing body, the entity responsible for the legal outcomes and responsible for the day to day operation of the hospital were unaware that mid-level practitioners, specifically physician assistants, were operating in the urgent care area of the emergency department of the hospital, performing medical screening examinations, assessing, medicating and discharging patients, unsupervised by a member of the medical staff.	A 156	Finding 3 Immediate Actions: The Interim Chief Medical Officer, to correct problems associated with the use of PAs in furtherance of the objectives of the quality improvement program, notified the ED Medical Director that PAs would no longer perform medical screening exams. He also subsequently informed the ED that PAs were not to be used for any purpose in the ED. (Attachments R, X) Permanent Actions: Use of the monitoring below will assure that the deficiency remains corrected. The QI director will provide remedial training where a pattern of deficient practices is determined.	6/18/07 6/19/07

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A 156	Continued From page 24 The Hospital Administrator was unaware that the Medical Staff bylaws had no provision to permit a physician assistant to perform emergency department medical screening examinations for patients presenting for the evaluation of an emergency medical condition. Patients #62, #63, #64, #65, #66, and #67 had been triaged on 5/31/2007 and sent to the urgent care unit of emergency department. No documentation for physician oversight for these patients was evident or provided. When interviewed on 5/31/20007 at approximately 1030 hours, the PA-C readily disclosed that an emergency department physician came to the urgent care area periodically to sign-off the charts. However, no written entries to document the quality or appropriateness of care was evident. The physician assistant revealed that the charts had been signed well after discharge of the patients from the emergency department. 4. The physician contract to provide neurosurgical coverage to the hospital expired on 04/30/2007. The governing body meeting minutes documented a continuing need for this coverage and a plan to provide this service, however, as of 06/07/2007, this plan had not been implemented to prevent similar patient safety issues. Cross reference to A0028.	A 156	Finding 3 (cont'd) Monitoring: Beginning 6/20/07 UR nurses review a minimum of ten randomly selected charts weekly to assess documentation that medical screening examination was performed by a physician. Deficiencies will be reported to the ED Collaborative Committee/Department of Emergency Medicine and Physician Performance Improvement Committee/QPIC and the Executive Committee, and when appropriate, the Governing Body. Once consistency is established, a minimum of ten charts per month will be reviewed. Position Responsible: ED Medical Director QI Director	
A 157	482.21(c)(3) QAPI IMPROVEMENT ACTIONS The hospital must take actions aimed at performance improvement. This STANDARD is not met as evidenced by:	A 157		

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A 157	Continued From page 25 Based on interviews, a review of documents and a review of minutes of the quality assessment, performance improvement committee, the hospital failed to ensure that performance improvement action plans had been implemented to prevent subsequent adverse patient events. Findings: Patient # 50 came to the hospital on 03/28/2007 for the evaluation of a neurosurgical emergency. (See A0455). Interviews conducted with the Medical Director of the hospital on 06/01/2007 and a review of an administrative document of 03/07/2007 and 03/12/2007, revealed that neurosurgical back up specialty coverage had been scheduled to terminate on 02/28/2007. However, arrangements had been made to extend Neurosurgical coverage by staff surgeons" through 04/2007." Thus, back up specialty neurosurgical coverage and intervention by staff surgeons had been provided. Emergency department physicians were unaware that contractural coverage had been extended and available. The emergency department physician staff thus failed to notify the on call neurosurgeon of the presence of Patient #50, who required urgent surgical intervention. The physician contract to provide neurosurgical coverage to the hospital expired on 04/30/2007. The governing body meeting minutes documented a continuing need for this coverage and a plan to provide this service, however, as of 06/07/2007, this plan had not been implemented to prevent similar patient safety issues.	A 157	**Immediate Action:** The Interim Chief Medical Officer sent a memorandum to all clinical services instructing them to assure that all staff are informed wherever there is a change in the scope of clinical services available at the hospital. **Permanent Action:** The monitoring process described below will be used to assure the continuing effectiveness of the corrective action. **Monitoring:** Notice of the change in the scope of services available will be forwarded to the Chief Medical Officer, who will verify that notification has been distributed hospital-wide. **Responsible Position:** Chief Medical Officer	7/9/07
A 167	482.21(e) EXECUTIVE RESPONSIBILITIES	A 167		

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A 167	Continued From page 26 The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring that specific QAPI program requirements are met. This STANDARD is not met as evidenced by: Based on interviews, review of documents from the hospital, a review of minutes of committees from the hospital and a review of 68 closed medical records, the governing body failed to ensure that specific QAPI program requirements, to focus on high risk-problem prone areas of the ED service, and taking corrective action to improve patient safety, were met. Findings: 1. When interviewed at approximately 1630 hours on 6/1/2007, the Hospital Administrator for Los Angeles County, and representative of the governing body, the entity responsible for the legal outcomes and responsible for the day to day operation of the hospital were unaware that mid-level practitioners, specifically physician assistants, were operating in the urgent care area of the emergency department of the hospital, performing medical screening examinations, assessing, medicating and discharging patients, unsupervised by a member of the medical staff. The Hospital Administrator was unaware that the Medical Staff bylaws had no provision to permit a physician assistant to perform emergency department medical screening examinations for	A 167	Immediate Actions: The Governing Body approved a Quality Improvement Plan which was developed by the Quality Council that focuses on problem prone, high risk areas of the hospital. Under the approved QI Plan data collected from all hospital departments is reported to the QPIC. Monthly the QPIC will evaluate data, including data that only physicians do all medical screening examinations in the ED, create corrective actions as necessary, and report to the Quality Council and Executive Committee and as appropriate, the Governing Body. Additionally, each standing meeting the Quality Council will review the findings of any Sentinel Event review findings. The findings will be reported to the Executive Committee and Governing Body. The corrective action plans will be disseminated to all hospital departments and services. Monitoring: The Governing Body monitors the effectiveness of the QI Plan through monthly reports from the Quality Council at each Governing Body meeting.	

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A 167	Continued From page 27 patients presenting for the evaluation of an emergency medical condition. Patients #62, #63, #64, #65, #66, and #67 had been triaged on 5/31/2007 and sent to the urgent care unit of emergency department. No documentation for physician oversight for these patients was evident or provided. When interviewed on 5/31/20007 at approximately 1030 hours, the PA-C readily disclosed that an emergency department physician came to the urgent care area periodically to sign off the charts. However, no written entries to document the quality or appropriateness of care was evident. The physician assistant revealed that the charts had been signed well after discharge of the patients from the emergency department. Cross reference to A0156. 2. Cross reference to A0153, for failure to identify high risk patient safety issues to influence performance improvement.	A 167		
A 169	482.21(e)(1) EXECUTIVE RESPONSIBILITIES The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring that an ongoing program for patient safety, including the reduction of medical errors, is defined, implemented and maintained. This STANDARD is not met as evidenced by: Based on interviews, a review of documents supplied by the hospital, and a review of closed patient records, the hospital's governing body	A 169	**Immediate Actions:** Under instructions from the Governing Body, a new QI Plan was developed and implemented. In the new QI plan, hospital-wide, department specific indicators for problem prone, high risk areas have been developed. These indicators specifically look at consults in the ED. **Permanent Actions:** Use of the monitoring below will assure that the deficiency remains corrected. The QI Director will provide remedial training where a pattern of deficient practices is determined. **Monitoring:** Monitoring on data collection will be done by the Director of Quality or her designee, will use a checklist every two weeks for three months and then monthly thereafter to assure that data collection and trending is occurring. Deficiencies will be addressed immediately with the responsible supervisor. Summaries of findings will be	

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A 169	Continued From page 28 failed to ensure that an ongoing program for patient safety, including the reduction of medical errors, had been defined, implemented and maintained. Findings: Patient #50 came to the emergency department of the hospital for evaluation of an emergency medical condition on 2/28/2007. Patient #50 was diagnosed with a brain tumor resulting in obstructive hydrocephalus, requiring "stat" transfer for a higher level of care for emergent neurosurgical intervention. When reviewed, the medical record for Patient #50 failed to disclose a physician intervention to stabilize, treat, or to effect a physician to physician dialogue to facilitate the transfer. The medical record for Patient #50 failed to contain any progress assessments to evaluate the neurological status for the patient. On 3/3/2007, the family of Patient #50 signed the patient out of the facility and went directly to a local general acute care hospital where neurosurgical intervention was performed in the emergency room, in an effort to relieve the pressure on the brain of Patient #50. When reviewed, the medical director of the emergency department wrote that Patient #50 had received appropriate physician care. However, a "Case Review Summary," performed by risk management noted that there was a "Failure to document physician assessment" and a "Delay in transfer to a neurosurgical bed." When reviewed, during the survey of 5/28/07 to 6/7/07, there was no documentation to indicate that the governing body had initiated or requested a program to ensure patient safety or to reduce	A 169	forwarded to QPIC quarterly. Monitoring of ED consideration of psychiatric specific indicators will be done by the ED Medical Director through Department minutes. Position Responsible: ED Medical Director QI Director	

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A 169	Continued From page 29 medical errors. There was no written documentation to indicate that the governing body had implemented or maintained a program to reduce medical errors.	A 169	**Permanent Action:** Use of the monitoring below will assure that the deficiency remains corrected. The QI Director will provide remedial training where a pattern of deficient practices is determined. **Monitoring:** The Director of Quality Improvement or her designee will use a checklist every two weeks for the first three months and then monthly thereafter, to assure that data collection and trending is occurring. Deficiencies will be addressed immediately with the responsible supervisor. Summaries of her findings will be forwarded to the QPIC quarterly. **Position Responsible:** QI Director Finding 3 **Immediate Action:** The Interim Chief Medical Officer at each Medical Department meeting discussed the requirement that issues and concerns are to be disclosed and openly discussed to identify contributing factors, root cause and a plan of action. The information and any follow-up will be presented to the Executive Committee for consideration and input and if appropriate, to the Governing Body. Medical staff were reminded to follow chain of command when issues are not addressed or resolved. **Permanent Actions:** Inform and reinforce with physicians that they may confidentially and anonymously report any care concern, including adverse event, medication errors, staffing concerns, through the Patient Safety Network. **Monitoring:** DHS staff and hospital risk management monitors and assures follow-up of matters raised on the Patient Safety Network. **Immediate Action:** The Governing Body, acting through the director of Health Services issued the Interim Chief Medical Officer and the President of the PSA that cases which disclose systemic issues should be included in the reports provided to the Governing Body, and asked that where no systemic issues have been identified since the last report, that such a fact be stated (Attachment Z	7/9/07
A 181	482.22 MEDICAL STAFF The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of care provided to patients by the hospital. This CONDITION is not met as evidenced by: Based on interviews, a review of the medical staff bylaws and the rules and regulations of the medical staff, the hospital failed to ensure that an organized medical staff operated under bylaws approved by the governing body and was responsible for the quality of care provided to patients by the hospital. The hospital failed to ensure that the medical staff had been organized and integrated as one body that operated under one set of bylaws approved by the governing body. The hospital failed to ensure that the medical staff bylaws applied equally to all practitioners within each category of practitioners at all locations of the hospital and to the care provided at all locations of the hospital. The medical staff is responsible for the quality of medical care provided to patients by the hospital. Findings: 1. The medical staff failed to ensure that emergency department staffing had been consistent with the medical staff bylaws and appropriate to meet the needs of the patients presenting for evaluation of an emergency medical condition. (A0186)	A 181		

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A 181	Continued From page 30 2. The medical staff failed to evaluate the waiting times of patients presenting to the emergency department. (A0153) 3. The medical staff failed to appropriately report concerns of the medical staff to the governing body to influence the quality of care being provided to patients in the emergency department.. (A0185). 4. The medical staff failed to enforce its own bylaws to ensure the quality and appropriateness of care for each of its patients presenting to the emergency department for the evaluation of an emergency medical condition. (A0186). The cumulative effects of these systemic problems resulted in the medical staff's inability to ensure the provision of medical care in a safe environment.	A 181	The Senior Medical Director, as a delegate of the Governing Body, will attend and participate in the Performance Improvement Committee of the PSA and the Quality Council to assure that Governing Body is aware of quality issues and can assure that such issues are addressed by the hospital processes. **Permanent Action:** The monitoring below is designed to assure that the corrective actions remain effective. **Monitoring:** Hospital Administration will review reports to Governing Body to assure that cases raising systemic issues are included Deficiencies will be address with PSA President and Medical Administration. **Responsible Person:** Hospital Administrator	
A 185	482.22(b) MED STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. The medical staff must be organized in a manner approved by the governing body. If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy. The responsibility for organization and conduct of the medical staff must be assigned only to an individual doctor of medicine or osteopathy or, when permitted by State law of the State in which	A 185		

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A 185	Continued From page 31 the hospital is located, a doctor of dental surgery or dental medicine. This STANDARD is not met as evidenced by: Based on interviews, a tour of the emergency department and service areas and a review of facility documents, the medical staff failed to be well organized and accountable to the governing body of the hospital, for the quality and appropriateness of care being provided to patients presenting to the emergency department for evaluation of an emergency medical condition. Findings: A tour of the emergency department was conducted on 5/31/07 at approximately 1030 hours. Interviews were conducted with the Medical Director of the emergency department and MD S, a staff emergency physician. It was stated that two physicians were provided to staff the emergency department for the majority of the hours of the day. A third physician was provided for approximately two hours, mid-day. The medical director stated that the emergency department was "over staffed" and had more than sufficient physicians to provide for patient care. When asked what physician staffing plans were available when one physician left the main department to provide coverage for a trauma patient, or to supervise patients in the Urgent Care area, or to leave the department for a meal or break, or to evaluate events in the waiting area, it was stated that physician coverage was more than adequate to meet the needs of the	A 185	**Immediate Actions:** A multidisciplinary group reviewed and revised emergency registration/admitting policy #1.1.32 entitled Registration and Financial Screening to require original time of arrival to be entered into the computerized central log to be congruent with the nursing flow sheet. IT re-programmed the central log to default to display or print in date time sequence regardless of triage location. **Permanent Actions:** Use of all monitoring below will assure that the deficiency remains corrected. The HIM director will provide training where a pattern of deficit practice is determined. **Monitoring:** Beginning July 1, 2007, PFS personnel review the central EMTALA log to track and trend wait times from triage to medical screening examination as well as ED length of staff weekly. Average wait times from triage to medical screening examination that exceed expectations will prompt a medical record review, the central log will be reconciled for inconsistencies with the medical record. Data on average wait times from triage to medical screening examination as well as ED length of stay will be presented to the ED Collaborative on a monthly basis along with other identified indicators t analyze and formulate corrective action and performance improvement plans. Once a baseline has been established wait times from triage to medical screening examination as well as ED length of stay will be trended monthly. **Responsible Persons:** HIM Director and ED Medical Director The Interim Chief Medical Officer at each medical department meeting discussed the requirement that issues and concerns are to be disclosed and openly discussed to identify contributing factors, root cause and a plan of action. The information and any follow-up will be presented to the Medical Executive Committee for consideration and input and, if appropriate, to the Governing Body. Medical Staff were reminded to follow chain of command when issues are not addressed and resolved.	

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A 185	Continued From page 31 the hospital is located, a doctor of dental surgery or dental medicine. This STANDARD is not met as evidenced by: Based on interviews, a tour of the emergency department and service areas and a review of facility documents, the medical staff failed to be well organized and accountable to the governing body of the hospital, for the quality and appropriateness of care being provided to patients presenting to the emergency department for evaluation of an emergency medical condition. Findings: A tour of the emergency department was conducted on 5/31/07 at approximately 1030 hours. Interviews were conducted with the Medical Director of the emergency department and MD S, a staff emergency physician. It was stated that two physicians were provided to staff the emergency department for the majority of the hours of the day. A third physician was provided for approximately two hours, mid-day. The medical director stated that the emergency department was "over staffed" and had more than sufficient physicians to provide for patient care. When asked what physician staffing plans were available when one physician left the main department to provide coverage for a trauma patient, or to supervise patients in the Urgent Care area, or to leave the department for a meal or break, or to evaluate events in the waiting area, it was stated that physician coverage was more than adequate to meet the needs of the	A 185	**Background:** The ED Medical Director misspoke when reviewing ED staffing. A review of the staffing schedules for July reflects the following: The main Emergency Department is currently staffed with three physicians each shift. This allows for coverage when one physician leaves the main department for any reason. The Urgent Care is staffed with one physician from 8:00 a.m. to 12:p.m., two physicians from 12:00 p.m. to 8:00 p.m. and one physician from 8:00 p.m. – 12:00 a.m. Urgent Care is closed from 12:00 a.m. to 8:00 a.m. Physician coverage can be redistributed as needed and is adjusted based on need. **Immediate Action:** As discussed in more detail on page 30 above, the hospital is tracking and trending a variety of data on wait times in the ED. When adequate data is available, the Department of Emergency Medicine will re-evaluate standard ED staffing patterns and make modifications as appropriate. **Permanent Action:** The monitoring process described below will assure the effectiveness of this corrective action. **Monitoring:** The Chief Medical Officer will review the minutes of the Department of Emergency Medicine to assure that the re-evaluation occurs. **Responsible Position:** Chief Medical Officer	

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A 185	Continued From page 32 emergency department patients. During this tour, it was learned that Physician Assistants (PA-Cs), were providing autonomous coverage in the urgent care unit of the emergency department, without physician supervision. Cross reference to A0028. When asked to provide a plan for the evaluation of patient waiting times, the medical director stated that chart reviews were conducted to provide documentation of the quality of care. However, these were not produced when requested. When interviewed, it was revealed that the average time to be evaluated and discharged from the emergency department was 14 hours. The medical director of the hospital, and medical director of the emergency department stated that long wait times were the norm in all hospital emergency departments. Please see A0459, Number 2 for examples of long patient wait times. Separate confidential interviews were conducted with two long term staff physicians on 06/01/2007 at approximately 1230 hours. Both physicians stated that there was considerable concern regarding physician staffing in the emergency department. Both physicians stated that a new emergency physician group had assumed responsibility for the emergency department on or about 12/01/ 2006. Both physicians were concerned that long wait times were a result of insufficient physician staffing to provide coverage for the patient population, known for its high acuity, underserved population. Both physicians independently stated that they were powerless to effect any change through medical staff or governing body intervention.	A 185	The Chief Medical Officer notified the ED Medical Director that physician assistants shall no longer perform medical screening examinations. (Attachment B) The ED Medical Director informed the physician assistants by e-mail that they may no longer perform medical screening examinations. All medical screening examinations are performed by a physician. (Attachment C) **Permanent Action:** The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Medical Director will address deficiencies with responsible personnel. **Monitoring:** For the next 30 days, Monday through Friday, Quality Improvement staff will review ten randomly selected open medical records in the ED to validate that medical screening examinations are performed by a physician. The ED Medical Director will be notified of discrepancies for immediate corrective action. **Responsible Positions:** Chief Medical Officer ED Medical Director **Immediate Action:** The Interim Chief Medical officer at each Medical Department meeting discussed the requirement that issues and concerns are to be disclosed and openly discussed to identify contributing factors, root cause and a plan of action. The information and any follow-up will be presented to the Executive Committee for consideration and input and, if appropriate, to the Governing Body. Medical staff were reminded to follow chain of command when issues are not addressed or resolved. **Permanent Action:** Inform and reinforce with physicians that they may confidentially and anonymously report any care concern, including adverse event, medication errors, staffing concerns, through the patient safety network.	6/8/07 6/7/07 6/07-7/07
A 186	482.22(c) MEDICAL STAFF BYLAWS	A 186		

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A 186	Continued From page 33 The medical staff must adopt and enforce bylaws to carry out its responsibilities. This STANDARD is not met as evidenced by: Based on interviews, a review of selected documents from the hospital, and a review of closed patient medical records, the medical staff failed to enforce its own bylaws to ensure the quality and appropriateness of care for Patients #3,#28, #29, and #49, presenting to the emergency department for the evaluation of an emergency medical condition. Findings: 1. Patient # 3 came to the emergency department of the hospital at 2130 hours on 04/30/2007. Patient # 3 was experiencing auditory hallucinations instructing him to drink bleach with the intent of suicide. Patient # 3 was not evaluated by a physician until 0500 hours on 05/01/2007. 2. Patient #28 came to the emergency department with severe depression and was assessed as having suicidal ideation. Patient #28 was logged in to the emergency department log at 2106 hours on 04/28/2007. Patient #28 was instructed to wait in the waiting area until 0015 hours, on 04/29/2007 when he was taken to the treatment area of the hospital. 3. Patient #29 came to the emergency department of the hospital at 1655 hours on 04/28/2007. Patient #29 was suicidal with a plan and came to the hospital after ingesting an unknown quantity of Elavil, a tricyclic antidepressant medication, known to produce	A 186	Psychiatric evaluations are now provided by the Los Angeles County PMRT personnel because there is no longer an inpatient psychiatric service at this facility. Findings 1-4 Immediate Actions: The Psychiatric Transfer Preparation and Management form has been revised and now addresses the documentation status of pending PMRT consultations and inpatient bed placement for patients in the ER. This form includes: (Attachment W) • License Registered Nurse will document Psych Risk assessment at initial assessment and with subsequent reassessment every shift. Assess for (1) danger to self (2) danger to others (3) identify sitter at bedside by name. Triage: Psych patients meeting any of the risk criteria are not to wait in the waiting room. • Sitters (nursing attendant) document interventions and patient's behavior hourly. • Follow-up a minimum of every four hours for the status of the pending PMRT evaluation and bed availability. The licensed nurse will document in the patient's medical record the above status a minimum of every four hours. • Upon discovery a licensed nurse will immediately notify the charge nurse and physician of any elopements or difficulties with placement. • The staff will maintain a daily log book in which they will keep the patient's individual status report. Once psychiatric report log sheet is used for one patient within a 24 hour period. • The above log will be kept in the ED in a binder labeled Psychiatric Patient Daily Log. • Charge Nurse: psych patients will be identified on the daily patient list and faxed to the Department of Health Services mental health liaison.	

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A 186	Continued From page 34 cardiac toxicity in high dosage. Patient #29 was not taken to the treatment area until 1750, and not evaluated by a physician until 1800 hours. 4. Patient #49 presented to the emergency department on 3/6/07 at 0302 hours, with a chief complaint of violent behavior, not taking his medications and was experiencing auditory hallucinations. The patient had arrived from another local area hospital. The patient was identified as having left without being seen at 0535 hours. Policy and Procedure #118, Management of Psychiatric Patients, mandates that psychiatric patients with assessed risks for being a danger to self, a danger to others or gravely disabled, must be taken directly to the treatment area to have a medical screening examination. the governing body failed to ensure that the medical staff complied with its own Policy and Procedures for the treatment of patients coming to the emergency department with a Psychiatric emergency. Number 105, of the medical staff rules and regulations described, "Any patient evaluated in the emergency room..who is known or suspected to be suicidal, otherwise self injurious, or has taken a chemical overdose shall have psychiatric consultation." Number 69 of the medical staff rules and regulations stated that patients were to be seen within one hour for emergency consultations. 5. The medical staff by-laws, and the rules and regulations and PA-C credential files did not specify which types of practitioners could provide medical screening examinations in the ED. There	A 186		

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A 186	Continued From page 35 was no documentation delineating such privileges for a physician assistant (PA-C) performing examinations in the ED. There was no documentation present in the PA-C privileging forms, to assess the qualifications and competence to provide medical screening examinations and/or to determine if an emergency medical condition existed. 5. a. Patients #62, #63, #64, #65, #66, #67, #68 were triaged on 5/30 and/or 5/31/07 and sent to the Adult Urgent Care area for their medical screening examinations and treatment. Each patient had their medical screening examination and treatment done by a PA-C. Medical record reviews revealed the patients were evaluated, treated and discharged from Adult Urgent Care, prior to the time of supervision or monitoring by the ED physician. The hospital failed to ensure that the patients were seen by a physician. The medical record for each patient failed to demonstrate a timed entry by the emergency department physician. When interviewed on 5/31/07 at approximately 1030 hours, the PA-C stated medical screening examinations were provided by the PA-C. It was stated that the assigned/designated supervising ED physician made rounds every two hours to sign the patient's medical record. 5. b. Patients #5, #7, #9 and #15 received their medical screening examination conducted in the main emergency room treatment area. Review of the medical records failed to provide documented evidence that the supervising physician had evaluated the patient care provided by PA-Cs. There were no timed co-signatures of the records by a supervising physician.	A 186	Finding 5 We note that the medical staff rules do contain a discussion of the types of persons who may provide screening examinations (Attachment Y). To assure conformity with the medical staff rules and regulations, the Chief Medical Officer notified the ED Medical Director that physician assistants shall no longer perform medical screening examinations (Attachment B). The ED Medical Director informed all Physician Assistants by e-mail that they ma no longer perform medical screening examinations. All medical screening examinations are performed by a physician. (Attachment C) **Permanent Action:** Use of the monitoring described below will assure that the deficiency remains permanently corrected. **Monitoring:** Starting July 1, 2007, Utilization Review Staff will review at least 15% of patients weekly to track and trend data from arrival to triage and arrival to medical screening exam. Time of arrival to time of discharge is tracked electronically through the Affinity System for all patients and trended weekly. The information goes to the Emergency Department Collaborative Committee for evaluation. The reports will go to both the ED Committee and the Quality/Performance Improvement Committee, which will report this to the Executive Committee or Quality Council respectively, and then to the Governing Body. **Responsible Position:** QI Director	6/8/07 6/7/07
A 199	482.23 NURSING SERVICES	A 199		

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A 199	Continued From page 36 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on hospital staff interviews, medical record reviews and review of hospital provided documentation, the hospital failed to have an organized nursing service. Findings: 1. Nursing services failed to ensure that a registered nurse supervised and evaluated the nursing care provided to patients. Cross reference to A0204. 2. Nursing Services failed to ensure that pain management was provided to patients in a timely manner. Cross reference to A0455 and A0456. 3. Nursing services failed to ensure that established policies and procures for patient care were followed. Cross reference to A0456 and A0459.. The cumulative effect of these systematic failures resulted in the nursing services' inability to ensure patients received nursing care in a safe environment.	A 199	Finding 1 – 3 **Immediate Actions** 1) Although each patient was seen by a registered nurse, specific problems in nursing care were revealed in these cases. Corrective actions in the form of counseling and retraining were implemented. For more detail, please see responses under tag A204 (page 37). 2) A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triage policy was revised so that the triage registered nurse notifies the medical provider if the patient is experiencing pain >7/10 and follows physicians order to initiate pain medication for pain relief regardless of acuity level. The ED Nurse Manager provided in-service on the revised triage policy #114. The ED Nurse Manager provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain, which requires interventions based on the pain policy. **Permanent Actions:** The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager will address deficiencies with responsible personnel. **Monitoring:** The ED Nurse Manager or designee will review ten randomly selected charts each week to assess ED patients for appropriateness of pain intervention based on pain score. Deficiencies will be addressed by the ED Nurse Manager. Data from the weekly reviews will be presented to the ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary and report it to Quality Council and Executive Committee, and as appropriate to the Governing Body. Once audits demonstrate consistency, monitoring will be limited to ten charts monthly. **Responsible Position:** Chief Nursing Officer ED Nurse Manager	6/21/07 6/5/07-6/14/07, 6/19/07
A 204	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate	A 204		

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A 204	Continued From page 37 the nursing care for each patient. This STANDARD is not met as evidenced by: Based on staff interviews, medical record reviews and review of hospital policies and procedures, the hospital failed to ensure that a registered nurse evaluated the nursing care provided to 11 of 68 sampled patients in the emergency areas of the hospital. (Patients #2, #3, #5, #6, #7, #26, #28, #29, #49, #50, #69). Findings: 1. Patient #50 presented to the Emergency Department at 0950 hours on 2/28/07 with a chief complaint of headache. The patient identified the intensity of headache as severe as evidenced by a reported intensity of 9/10, on a scale of zero to 10, with 10 being the most severe. The patient described his pain as being located at the back of his head and that the pain was relieved by vomiting. Nursing and physician assistant documentation identified that the patient had been experiencing headache pain and dizziness for three weeks, in addition to occasional nausea. At 1250 hours, Patient #50 was taken to the treatment area. The patient was assessed by the emergency department physician, at which time "paraspinal tenderness" was noted, but no " Neuro" changes or " Psych" abnormalities recorded. Morphine 4 mg was administered in the emergency department, however, the patient's response to the pain medication was not recorded. At 1550 hours Patient #50 was taken to CT. The scan revealed a brain tumor measuring	A 204	Finding 1 – 3 Immediate Actions 1) Although each patient was seen by a registered nurse, specific problems in nursing care were revealed in these cases. Corrective actions in the form of counseling and retraining were implemented. For more detail, please see responses under tag A204 (page 37). 2) A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triage policy was revised so that the triage registered nurse notifies the medical provider if the patient is experiencing pain >7/10 and follows physicians order to initiate pain medication for pain relief regardless of acuity level. The ED Nurse Manager provided in-service on the revised triage policy #114. The ED Nurse Manager provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain, which requires interventions based on the pain policy. Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager will address deficiencies with responsible personnel. Monitoring: The ED Nurse Manager or designee will review ten randomly selected charts each week to assess ED patients for appropriateness of pain intervention based on pain score. Deficiencies will be addressed by the ED Nurse Manager. Data from the weekly reviews will be presented to the ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary and report it to Quality Council and Executive Committee, and as appropriate to the Governing Body. Once audits demonstrate consistency, monitoring will be limited to ten charts monthly. Responsible Position: Chief Nursing Officer ED Nurse Manager	6/21/07 6/5/07-6/14/07, 6/19/07

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A 204	Continued From page 38 approximately 2.5 cm. compressing the internal circulation of fluid in the brain resulting in internal swelling from dilatation of the ventricular system of the brain. An MRI image of the brain was recommended and completed. This confirmed the presence of a tumor mass in the region of the pineal gland. Moderate dilatation of the ventricular system of the brain was noted. The patient was diagnosed with acute obstructive hydrocephalus. At 0350 hours on 3/1/07, nursing notes revealed that Patient #50 was administered Dilaudid (narcotic pain medication) by IVP (intravenously push). The pain assessment identified only the intensity of the pain the patient was experiencing (6/10) and that he had a headache. The assessment was incomplete. A nursing re-assessment performed at 0550 hours revealed that a neuro check had been performed and the headache pain of Patient #50 had improved. Patient #50 remained in the ED until 3/3/07. Review of the medical record revealed that the patient was assessed by nursing staff and continued to received Dilaudid and morphine to control his headache pain. The nursing pain assessments included only a numerical score to identify the intensity of pain but failed to identify pain radiation, quality (ache, throbbing, sharp, dull, burning) and constancy as required by established hospital policy. The medical record failed to provide documented evidence nursing staff caring for Patient #50 had requested that ED physicians evaluate the patient. On 3/3/07 at 0725 hours, nursing documentation identified that the patient complained of occipital headache pain. Intensity of pain was recorded as	A 204	A 199 (Cont'd) 3) Remedial actions in the form of counseling and reeducation on policies and procedures was implemented to assure compliance with policies and procedures. In addition, new pain reassessment documentation sheet was created to assist nurses in covering and recording all elements of a proper pain reassessment. Please see tags A 456 and A 459 below for more detail. **A 204** **Immediate Actions:** The ED Nurse Manager counseled the RN who gave morphine 4 mg, but did not follow up on the results of the medication administration. (Attachment N) 6/1/07 The Ed Nurse Manager educated all ED registered nurses on the requirements to record the results of medication administration (Attachment N) 6/06/07 **Permanent Actions:** The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager will address deficiencies with responsible personnel. **Monitoring:** Quality Improvement will review ten randomly selected charts weekly to assess documentation of results of pain mediations. Deficiencies will be addressed by the ED Nurse Manager. Data from these reviews will be presented to the Performance Improvement Committee and to the Executive Committees. Responsible Position: Chief Nursing Officer ED Nurse Manager	

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A 204	Continued From page 39 5/10. The patient was not given pain medication nor were non-medication interventions provided. Nursing documentation identified that Patient #50 had no deficits noted. However, the very next sentence stated c/o (complaint of) blurred vision when ambulating. Review of nursing documentation failed to provide documented evidence that the nurse caring for the patient had notified the patient's physician regarding the pain and blurred vision the patient was experiencing. The patient was not evaluated for the neurological symptom by a physician. At 1100 hours, nursing notes described that Patient #50 complained of increased head pain. The patient identified the intensity of pain as being 9/10 (severe). The nurse note failed to include a complete assessment of the patient's pain. The patient received Dilaudid 1 mg. IV for pain. Although a physician order was obtained for the pain medication, the patient's medical record failed to contain documented evidence that the nurse caring for the patient had insured that an ED physician evaluated the patient. At 1150 hours, nursing documentation revealed the patient and his family indicated, that after three days, they were tired of waiting for transfer to another hospital. The patient signed a Leaving Hospital Against Medical Advice form. The form was witnessed by the nurse caring for Patient #50. The form was noted to be incomplete. In addition, the medical record failed to contain documented evidence that at the time of discharge, the patient had been assessed by a physician or had received discharge instructions. Review of the hospitals's established policy titled, Discharge Instructions (#102), identified that all	A 204	Immediate Actions: The ED Nurse Manager counseled the RN who failed to assess the effectiveness of pain medication or to record the attributes of pain as required by policy. The ED Nurse Manger conducted in-service training for all ED RNs regarding appropriate documentation of pain assessments and the requirements for reassessment of after medication. Training was also provided on clear documentation standards. (Attachment N) A new pain reassessment documentation sheet was created to assist nurses in covering and recording all elements of a proper pain reassessment, including the effectiveness of pain medication. (Attachment AA) Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager will address deficiencies with responsible personnel. Monitoring: The ED Nurse Manager or designee will review ten randomly selected charts each week to assess ED patients for appropriateness of pain intervention based on pain score. Deficiencies will be addressed by the ED Nurse Manager. Data from the weekly reviews will be presented to the ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, crate corrective actions as necessary report it to Quality Council and Executive Committee, and as appropriate to the Governing Body. Once audits demonstrate consistency, monitoring will be limited to ten charts monthly. Responsible Positions: Chief Nursing Officer	6/19/07 6/6/07 7/05/07

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A 204	Continued From page 40 patients discharged from the emergency department would receive condition appropriate instructions for home care and appropriate referrals. Nursing documentation, via a check the box format, identified that Patient #50 who continued to have episodes of severe pain and blurred vision was being discharged in improved condition. The documentation also revealed that the patient with continued headaches and severe pain was discharged from the ED without medication to control future episodes of pain. On 6/5/07 a copy of the hospital's policy titled, Pain Management (#377), was received. The policy described that the nurse was to document with initial pain assessments the description, intensity, location, duration, quality and aggravating or alleviating factors based on the patient's self report. With each new report of pain an assessment was to be completed and factors were to include the description, intensity, location, duration, quality and aggravating or alleviating factors of the pain. The policy also described that when medication was administered to relieve pain, the effectiveness was to be documented within an hour for adults. The policy identified that pain assessments were to include pain intensity, pain location, quality of pain (sharp, dull, throbbing, shooting, aching, tearing), onset, duration variation and patterns, present pain management and effectiveness, pain management history and effects of pain (impact on activities of daily living, sleep, appetite, relationship with others and emotions). Pain assessments, reassessments, treatment modalities (distraction measures, repositioning, feeding, comfort measures), medication and effectiveness were to be documented in the patient record. Review of the medical record,	A 204	Immediate Actions The ED Nurse Manager and a nurse educator provided supplemental training to all ED RN staff on the importance of contacting physicians and the need to be a patient advocate. 6/5/07 The ED Nurse Manager counseled the ED nurse for failing to document notification of the physician when a change in condition was noted. 7/9/07 The ED Nurse Manager counseled the RN who failed to record the attributes of pain as required by policy. 6/19/07 The ED Nurse Manager conducted inservice training for all ED RNs regarding appropriate documentation of pain assessments and the requirements for reassessment after medication administration. Training was also provided on documentation standards. (Attachment N) 6/6/07 Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager, will address deficiencies with responsible personnel. Monitoring: The ED Nurse Manager or designee will review ten randomly selected charts each week to assess Ed patients for appropriateness of pain intervention based on pain score. Deficiencies will be addressed by the Ed Nurse Manager. Data from the weekly reviews will be presented to the ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary and report it to Quality Council and Executive Committee, and as appropriate to the Governing Body. Once audits demonstrate consistency, monitoring will be limited to ten charts monthly. Responsible Position: Chief Nursing Officer	

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A 204	Continued From page 41 including nursing notes failed to provide documented evidence that the nurses caring for Patient #50 had followed the hospital's established policy for pain management. 2. Patient #69 presented to the emergency department on 3/8/07, at 2242 hours, with a chief complaint of stomach pain for the past two weeks. The nurse documented that the pain was in all four quadrants and radiated in to the patient's back. It was documented that the patient had multiple episodes of nausea and vomiting today. The patient identified her pain as being severe with a score of 10 out of 10. The patient identified that the pain she was experiencing was constant and that nothing provided relief. The pain was further described as aching and burning with a pressure sensation. Nursing documentation revealed that the patient was moaning and had facial grimacing. Vital signs were recorded as Temperature 102.8 degrees, heart rate 97, respirations 24 and blood pressure was 133/59. No treatment was provided to alleviate pain or reduce the patient's fever at the time of triage. Two hours later, at 0040 hours, the patient's vital signs were re-assessed. The patient had a Temperature of 102.4 degrees, heart rate 102, respirations 20 and blood pressure was recorded as 118/62. The patient continued to experience severe abdominal pain. No treatments were provided. At 0110 hours, the patient was transferred to the treatment area. The patient continued to have severe pain, recorded as 7/10 without an on-going assessment as required by established policy. The patient received Tylenol 650 mg. and	A 204	Immediate Actions: The ED Nurse Manager provided education for all ED RNs on discharge assessments. Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager, will address deficiencies with responsible personnel. Monitoring: Ten randomly selected charts will be reviewed each week to validate completion of discharge assessments by RNs. Deficiencies will be discussed with the appropriate supervisor and results will be reported to Performance Improvement Committee, which will review and create corrective action as necessary. This data will then be reported to Executive Committee and to the Governing Body as appropriate. Responsible Position: Chief Nursing Officer	6/9/07

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A 204	Continued From page 42 was placed on oxygen by mask. At 0220 hours, the patient was described to have decreased pain. At 0400 hours, nursing documentation revealed that the patient had no orders for care and was waiting for the physician assistant. Patient #69 was not seen or evaluated by a physician until 0515 hours. The patient was described as having a fever (103. 4 degrees) and was in moderate to severe distress. The patient continued to experience severe pain and nausea. The pain was assigned an acuity of 10/10. The patient was assessed to have decreased bowel sounds and abdominal tenderness. Review of the medical record revealed a physician order, timed at 0530 hours, for morphine 2 mg. IV (intravenous) x 1 and 5 mg. Reglan (for nausea) IV x 1. Nursing notes for this time period do not provide evidence of a pain assessment as required by established policy or that the patient received the medication as ordered. At 0950 hours, 11 hours after presenting to the ED, the patient was transferred to surgery services to undergo an exploratory laparotomy. The ED nurse's discharge note did not provide evidence that the patient was evaluated for pain prior to being discharged to surgical services. Review of the preoperative nursing record dated 3/9/07 and times 0910 hours described that the patient was experiencing severe pain (10/10). 3. The medical record for Patient #5 documented he presented to the ED at 1139 hours on 5/11/07 with left flank pain. He was not seen by a triage nurse until three hours later to determine the severity of his symptoms. At 1448 hours, the	A 204	Immediate Actions: • The ED Nurse Manager counseled the nurse on her failure to address the patient's pain and instructed her to review the triage and pain management policies. (Attachment N) • A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triage policy was revised so that the triage registered nurse notifies medical provider if the patient is experiencing pain ≥ 7/10 and follows physicians order to initiate pain medication for pain relief regardless of triage acuity level. • The ED Nurse Manager provided in-service on the revised triage policy #114, which allows nurses to initiate interventions for pain relief. • The ED Nurse Manager provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain, which requires interventions based on the pain policy. • The ED Nurse Manger provided education to all ED RNs on all requirements to administer pain medication within 30 to 60 of physician's order. Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager, will address deficiencies with responsible personnel. Monitoring: > The ED Nurse Manager or designee will review ten randomly selected charts each week to assess ED Patients for appropriateness of pain intervention based on pain score. Deficiencies will be addressed by the ED Nurse Manager. Data from the weekly reviews will be presented to the ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary, and report it to the Quality Council and Executive Committee and as appropriate, the Governing Body.	6/19/07 6/21/07 6/5/07 – 6/14/07, 6/19/07 6/29/07-07/09/07

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A 204	Continued From page 43 triage nurse documented his pain was 8/10. At 1730 hours, the nurse documented the first full assessment of the patient. The patient was evaluated by a physician's assistant. There was no documented evidence a physician saw Patient #5. Pain medication was not administered to Patient #5 until 2100 hours, 9 and 1/2 hours after he presented to the ER. No further treatment was provided to Patient #5 and it was documented that he eloped from the ED at 0000 hours on 5/12/07. 4. The medical record for Patient #6 identified that he came to the ED at 1812 hours on 5/11/07 for a "surgical consult for (his) umbilical hernia." He was triaged at 1845 and complained of 5/10 pain. When he was called to the treatment area four hours later he did not answer. At 0100 the nurse documented Patient #6 left without being seen. No medical screening examination had been performed to determine if the patient had an emergency medical condition. 5. The medical record for Patient #7 showed she presented to the ED at 2045 hours on 5/11/07 for "spotting" during her pregnancy. She stated she was 2 months pregnant. At 2140 hours, she was triaged and a pregnancy test was documented as positive. When the patient was called to the treatment area 2 hours later, she had left without being seen. Patient #7 returned to the ED at 1306 hours on 5/14/07, with a complaint of vaginal bleeding for three days. She had 8/10 pain when triaged by the nurse at 1315 hours. There was no documented evidence the ED nurse evaluated how much the patient was bleeding. There was no documented re-assessment of her condition until she was taken to the treatment area four hours later at 1730 hours. No pain	A 204	Immediate Actions : The nurse responsible for the delay in administration of pain medication no longer works for the facility. The ED Nurse Manager provided education to all ED RNs regarding timeliness to pain medication administration from physician's order. Permanent Actions : The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager, will address deficiencies with responsible personnel. Monitoring: The ED Nurse Manager or designee will review ten randomly selected charts each week to assess ED patients for appropriateness of pain intervention based on pain score and timeliness to administration of medication. Deficiencies will be addressed by the ED Nurse Manager. Data from the weekly reviews will be presented to the ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary, and report it to the Quality Council and Executive Committee and as appropriate, the Governing Body. Immediate Actions: The ED Charge Nurse makes randomly spaced visits to the ED waiting area to validate that all patients awaiting care have been registered and are accounted for. The Nursing Supervisor makes similar visits on evening and night shifts. A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triage policy was revised so that the triage registered nurse notifies the medical provider if the patient is experiencing pain >7/10 and follows physicians order to initiate pain medication for pain relief regardless of acuity level. The ED Nurse Manager provided in-service on the revised triage policy #114. The ED Nurse Manager provided education to all ED RNs on the requirement to notify physicians of all patients	7/7/07 – 7/9/07 6/21/07 6/5/07 – 6/14/07, 6/19/07

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A 204	Continued From page 44 medication/intervention was given. She passed the products of conception while having an ultrasound done and was discharged by a physician at 2235 hours after having had a miscarriage. 6. Patient #2 came to the ED of the hospital on 4/30/07 at approximately 1207 hours. When triaged at 1250 hours, she identified she had sharp pain of 10, on a 1-10 scale, with 10 being the most severe. No pain interventions were initiated in the triage area. The patient was taken to the treatment area five hours later at 1815 hours and received pain medication one hour later.. Approximately 20 hours after she presented to the ED, at 0830 hours on 5/1/07, a general surgery consultation was provided to evaluate the acute abdominal pain for Patient #2. The patient was admitted to the hospital and had surgery for an exploratory laparotomy and ventral hernia repair. 7. The medical record for Patient #26 documented the teenager presented to the emergency department (ED) at 2355 hours, on 2/12/07 with right abdominal pain. He was triaged by the nurse and determined to have pain of 10 on a 1-10 scale (10/10). His oxygen saturation level was 100%, his pulse 95 respirations were 18 and his blood pressure was 113/69. At 0040 hours the nurse documented the patient was complaining of difficulty breathing. The nurse documented he had wheezing in his lungs, his respiratory rate was 22 , blood pressure was 135/70, oxygen saturation was 97% and that he was anxious and restless. There was no documentation about why he was left in the lobby of the ED.	A 204	A204 cont'd from page 43 Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager will address deficiencies with responsible personnel. Monitoring: The ED Nurse Manager or designee will review ten randomly selected charts each week to assess ED patients for appropriateness of pain intervention based on pain score. Deficiencies will be addressed by the ED Nurse Manager. Data from the weekly reviews will be presented to the ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary and report it to Quality Council and Executive Committee, and as appropriate to the Governing Body. Once audits demonstrate consistency, monitoring will be limited to ten charts monthly. Responsible Position: Chief Nursing Officer ED Nurse Manager • The nurse responsible for the delay in administering the pain medication no longer works for the facility. • A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triage policy was revised so that the triage registered nurse notifies the medical provider if the patient is experiencing pain >7/10 and follows physicians order to initiate pain medication for pain relief regardless of acuity level. 6/21/07 • The ED Nurse Manager provided in-service on the revised triage policy #114. 6/5/07 – 6/14/07, 6/19/0 • The ED Nurse Manager provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain, which requires interventions based on the pain policy.	

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A 204	Continued From page 45 No pain medication or other pain relieving interventions were provided. There was no re-assessment of the patient until he was taken to a treatment area five hours later. At 0530 hours on 2/13/07, his pain was 8/10. At 0645 hours, laboratory tests and pain medication ,were ordered for Patient #26. The pain medication was administered at 0840 hours; two hours after being ordered and approximately 8 and 1/2 hours after he presented to the ED. Laboratory test results were not available until 2100 hours. This was approximately 14 hours after they were ordered and 19 hours after Patient #26 came to the ED. There was no documented evidence the nursing or medical staff were following-up to ensure the laboratory test results were obtained. During interviews on 6/1/07, medical staff stated this patient "fell through the cracks." 8. Number 105 of the medical staff rules and regulations stated " Any patient evaluated in the emergency room ... who is known or suspected to be suicidal, otherwise self injurious, or has taken a chemical overdose shall have psychiatric consultation." Number 69 of the medical staff rules and regulations stated that patients were to be seen within one hour for emergency consultations. Patients #3, #28, #29 and #49 presenting to the Emergency Department with psychiatric complaints failed to be taken to a treatment room upon arrival to the triage area and failed to receive an emergency consultation within one hour of arrival. Cross reference to A0153 and A0455.	A 204	A 204 Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager will address deficiencies with responsible personnel. Monitoring: The ED Nurse Manager or designee will review ten randomly selected charts each week to assess ED patients for appropriateness of pain intervention based on pain score. Deficiencies will be addressed by the ED Nurse Manager. Data from the weekly reviews will be presented to the ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary and report it to Quality Council and Executive Committee, and as appropriate to the Governing Body. Once audits demonstrate consistency, monitoring will be limited to ten charts monthly. Finding 5 Immediate Action: The ED Nurse Manager counseled the RN who did not evaluate the amount of bleeding. The ED Nurse Manager provided reeducation for all ED RNs on the need to reassess triaged patients in the ED waiting room based on new acuity and pursuant to the triage policy. Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager will address deficiencies with responsible personnel. Monitoring: Ten randomly selected ED medical records will be reviewed each week to assure clear documentation of patient events. Results of this audit will be presented to the Performance Improvement Committee which will review and create corrective actions as necessary. The data will then be reported to the Executive Committee.	
A 452	482.55 EMERGENCY SERVICES	A 452	Responsible Position: Chief Nursing Officer	

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A 452	Continued From page 46 The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This CONDITION is not met as evidenced by: Based on staff interview and review of policies and procedures, medical staff rules and regulations and medical records, the hospital: 1. Failed to ensure the immediate availability of services, qualified personnel and other hospital departmental services to provide prompt evaluation and treatment of patients presenting to the emergency department (A455, A459). 2. The hospital failed to follow their policies and procedures (P&P), by-laws, rules and regulations developed to ensure medical screening examinations were conducted by appropriately qualified individuals (A456). 3. The hospital failed to ensure on - call physicians saw patients when specialty consultation was requested. (A456). 4. The hospital failed to ensure pain management was provided in a timely manner (A455). 5. The hospital failed to ensure stabilizing treatment for emergency medical conditions was provided (A455) and failed to ensure timely transfer of individuals who needing a higher level of care transfer of patients who required services not available at the hospital (A455). The cumulative effect of these systemic failures resulted in an immediate threat to the health and safety of all patients presenting for treatment at the Emergency Department. At approximately	A 452	A204 Cont'd from Page 46 Finding 4 and 5 Immediate Actions A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of the review, the triage policy was revised so that the triage registered nurse notifies medical provider if the patient is experiencing pain ≥ 7/10 and follows physicians order to initiate pain medication for pain relief. The ED Nurse Manager provided in-service on the revised triage policy #114. The ED nurse manger provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain which requires interventions based on the pain policy. Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager, will address deficiencies with responsible personnel. Monitoring: The ED Nurse Manager or designee will review ten randomly selected charts each week to assess ED patients for appropriateness of pain intervention based on pain score. Deficiencies will be addressed by the ED Nurse Manager. Data from the weekly reviews will be presented to ED Collaborative Committee and will also be presented to the Performance Improvement Committee monthly, which will evaluate it, create corrective actions as necessary, and report it to the Executive Committee and as appropriate, the Governing Body. Responsible Position: Chief Nursing Officer Finding 6 Immediate Actions The ED Nurse Manager provided reeducation for all ED RNs on the need to reassess triaged patients in the ED waiting room, based on acuity and pursuant to the triage policy. The ED Nurse Manager provided reeducation to all ED RNs on the need to inform the physician on delays in the patient receiving a consultation.	6/21/07 6/5/07 – 6/14/07, 6/19/0

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A 452	Continued From page 46 The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This CONDITION is not met as evidenced by: Based on staff interview and review of policies and procedures, medical staff rules and regulations and medical records, the hospital: 1. Failed to ensure the immediate availability of services, qualified personnel and other hospital departmental services to provide prompt evaluation and treatment of patients presenting to the emergency department (A455, A459). 2. The hospital failed to follow their policies and procedures (P&P), by-laws, rules and regulations developed to ensure medical screening examinations were conducted by appropriately qualified individuals (A456). 3. The hospital failed to ensure on - call physicians saw patients when specialty consultation was requested. (A456). 4. The hospital failed to ensure pain management was provided in a timely manner (A455). 5. The hospital failed to ensure stabilizing treatment for emergency medical conditions was provided (A455) and failed to ensure timely transfer of individuals who needing a higher level of care transfer of patients who required services not available at the hospital (A455). The cumulative effect of these systemic failures resulted in an immediate threat to the health and safety of all patients presenting for treatment at the Emergency Department. At approximately	A 452	A204 Cont'd from page 45 Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager will address deficiencies with responsible personnel. Monitoring: The ED Nurse Manager or designee will review ten randomly selected charts each week to assess for appropriateness of triage acuity score based on the Emergency Severity Index, and, if applicable, whether the score was appropriately changed after the patient was reassessed. The ED Nurse Manager will address deficiencies with responsible individuals. Data from the weekly reviews will be presented to ED/QI. Data will also be presented to the Performance Improvement Committee monthly which will evaluate it, create corrective actions as necessary, and report it to the Executive Committee and as appropriate, the Governing Body. For the next 30 days, Monday through Friday, UR RNs will review ten randomly selected open medical records in the ED to validate that consults were performed by a physician; that there is a consulting physician's note; and that the consultation was timely. The Chair of the relevant department will be notified of discrepancies for immediate corrective action as necessary. The data will then be reported to the Executive Committee. Responsible Position: Chief Nursing Officer ED Nurse Manager	

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A 452	Continued From page 47 1530 hours on 6/7/07, hospital administration was notified of the immediate jeopardy.	A 452		
A 455	482.55(a)(2) INTEGRATION OF EMERGENCY SERVICES The services must be integrated with other departments of the hospital. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the hospital failed to ensure the timely provision of emergency services to meet the needs of 20 of 68 sampled patients presenting for evaluation of an emergency medical condition. (Patients #2, #3, #5, #6, #7, #9, #15, #23, #26, #36, #49 #50, #62, #63, #64, #65, #66, #67, #68,and #69). The hospital failed to: 1. Follow their policies and procedures (P&P), by-laws, rules and regulations developed to ensure medical screening examinations were conducted by appropriately qualified individuals. 2. Ensure on - call physicians saw patients when back up specialty consultation was required. 3. Ensure pain management was provided in a timely manner, 4. Provide stabilizing treatment for emergency medical conditions. 5. Ensure timely transfer of individuals who required a higher level of care transfer for services not available at the hospital. The cumulative effect of these systemic failures resulted in an immediate threat to the health and safety of all patients presenting for treatment at the Emergency Department. At approximately 1530 hours on 6/7/07, hospital administration was	A 455	Finding #1 & 2 Immediate Actions • The Chief Medical Officer notified the ED Medical Director that physician assistants shall no longer perform medical screening examinations. (Attachment B) — 6/8/07 • The ED Medical Director informed the physician assistants by e-mail that they may no longer perform medical screening examinations. All medical screening examinations are performed by a physician. (Attachment C) — 6/7/07 Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. Monitoring • Ten randomly selected medical records will be reviewed daily to track the time from triage to medical screening examination. Data from these daily reviews will be presented to the ED Collaborative Practice Committee and the process will be re-evaluated as a result of this review. Data will also be presented to the Performance Improvement Committee monthly, which will evaluate it, develop corrective actions as necessary, and report it to the Executive Committee and as appropriate to the Governing Body. Once the process is stable, the daily record review will convert to a monthly review. Position Responsible: ED Medical Director ED Nursing Manager Chief Medical Officer	

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A 452	Continued From page 47 1530 hours on 6/7/07, hospital administration was notified of the immediate jeopardy.	A 452	Finding #3 Immediate Actions: • The Interim Chief Medical Officer ordered all MLK Department Chiefs to discontinue the practice of using Physician Assistants for consultations in the ED. All ED consultations will be performed by an attending physician. (Attachment BB)	6/14/07
A 455	482.55(a)(2) INTEGRATION OF EMERGENCY SERVICES The services must be integrated with other departments of the hospital. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the hospital failed to ensure the timely provision of emergency services to meet the needs of 20 of 68 sampled patients presenting for evaluation of an emergency medical condition. (Patients #2, #3, #5, #6, #7, #9, #15, #23, #26, #36, #49 #50, #62, #63, #64, #65, #66, #67, #68,and #69). The hospital failed to: 1. Follow their policies and procedures (P&P), by-laws, rules and regulations developed to ensure medical screening examinations were conducted by appropriately qualified individuals. 2. Ensure on - call physicians saw patients when back up specialty consultation was required. 3. Ensure pain management was provided in a timely manner, 4. Provide stabilizing treatment for emergency medical conditions. 5. Ensure timely transfer of individuals who required a higher level of care transfer for services not available at the hospital. The cumulative effect of these systemic failures resulted in an immediate threat to the health and safety of all patients presenting for treatment at the Emergency Department. At approximately 1530 hours on 6/7/07, hospital administration was	A 455	• The ED Nurse Manager provided a letter instructing all Ed RN's regarding Physician Assistants cannot provide consults. (Attachment J) • The Interim Chief Medical Officer instructed all Department Chiefs to ensure that all attending physicians are aware of the need to document their consultations (Attachment 5 Permanent Action: The monitoring process described below assure the continuing effectiveness of these corrective actions. Monitoring: • For the next 30 days, Monday through Friday, Qualified Improvement staff will review ten randomly selected open medical records in the ED to validate that consults were performed by a physician and that there is a consulting physician's note. The Chair of the relevant department will be notified of discrepancies for immediate corrective action. • Ten randomly selected ED records of patients will be reviewed each week to validate the presence of the attendees note. Results of these audits will be presented to the Performance Improvement Committee, which will review and create corrective actions as Necessary. This data will then be reported to the Executive Committee and to the Governing Body as appropriate. The Chair of the service will be notified of discrepancies for corrective actions. Position Responsible: Interim Chief Medical Officer Immediate Actions: • ED nurse manager counseled the RN who gave morphine 4mg, but did not receive the results of the medication administration. • ED nurse manager educated all ED registered nurses on the requirements to record the results of medication administration. (Attachment H)	6/19/07 6/19/07 7/1/07 6/19/07 6/15/07

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A 452	Continued From page 47 1530 hours on 6/7/07, hospital administration was notified of the immediate jeopardy.	A 452	Finding #4 **Immediate Actions:** • ED nurse manager counseled the RN who gave morphine 4 mg, but did not receive the results of the medication administration. • ED nurse manager educated all ED registered nurses on the requirements to record the results of medication administration (Attachment).	
A 455	482.55(a)(2) INTEGRATION OF EMERGENCY SERVICES The services must be integrated with other departments of the hospital. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the hospital failed to ensure the timely provision of emergency services to meet the needs of 20 of 68 sampled patients presenting for evaluation of an emergency medical condition. (Patients #2, #3, #5, #6, #7, #9, #15, #23, #26, #36, #49 #50, #62, #63, #64, #65, #66, #67, #68,and #69). The hospital failed to: 1. Follow their policies and procedures (P&P), by-laws, rules and regulations developed to ensure medical screening examinations were conducted by appropriately qualified individuals. 2. Ensure on - call physicians saw patients when back up specialty consultation was required. 3. Ensure pain management was provided in a timely manner, 4. Provide stabilizing treatment for emergency medical conditions. 5. Ensure timely transfer of individuals who required a higher level of care transfer for services not available at the hospital. The cumulative effect of these systemic failures resulted in an immediate threat to the health and safety of all patients presenting for treatment at the Emergency Department. At approximately 1530 hours on 6/7/07, hospital administration was	A 455	**Immediate Action:** • The ED nurse manager designated a nurse educator to provide reinforced education of ED policy #114 to ensure that patients are appropriately triaged and assigned a triage acuity level based on the Emergency Severity Index. The nurse educator provided this supplemental training. • A multidisciplinary team of ED physician and ED nurses reviewed the current triage process. As a result of that review, the triage policy was revised so that the triage registered nurse notifies medical provider if the patient is experiencing pain ≥ 7/10 and follows physician order to initiate pain medication for pain relief regardless of triage acuity level. • The ED nurse manager provided in-service on the revised triage policy #114. • The ED nurse manager provided education to all ED RNs on the requirement to notify physician of all patient waiting to be seen that are experiencing pain, which requires interventions based on the pain policy. **Permanent Actions:** The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED nurse manager, will address deficiencies with responsible personnel. **Monitoring:** The ED nurse manager or designee will review ten randomly selected charts each week to assess for appropriateness of triage acuity score based on the Emergency Severity Index, timely reassessment based on triage level and triage score adjust. If needed, and pain intervention based on pain score. The ED nurse manager will address deficiencies with responsible individuals. Data from the weekly reviews will be presented to ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective action as necessary, and report it to the Executive Committee and as appropriate Governing Body. Once audits demonstrate	

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A 452	Continued From page 47 1530 hours on 6/7/07, hospital administration was notified of the immediate jeopardy.	A 452	Consistency, monitoring will be limited to 10 charts monthly. The charge nurse on each shift will be responsible for reviewing the people in the ED waiting room at least once per shift to determine whether they are patients waiting for service. Anyone without an identification band will be questioned as to their status and appropriately directed.	
A 455	482.55(a)(2) INTEGRATION OF EMERGENCY SERVICES The services must be integrated with other departments of the hospital. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the hospital failed to ensure the timely provision of emergency services to meet the needs of 20 of 68 sampled patients presenting for evaluation of an emergency medical condition. (Patients #2, #3, #5, #6, #7, #9, #15, #23, #26, #36, #49 #50, #62, #63, #64, #65, #66, #67, #68,and #69). The hospital failed to: 1. Follow their policies and procedures (P&P), by-laws, rules and regulations developed to ensure medical screening examinations were conducted by appropriately qualified individuals. 2. Ensure on - call physicians saw patients when back up specialty consultation was required. 3. Ensure pain management was provided in a timely manner, 4. Provide stabilizing treatment for emergency medical conditions. 5. Ensure timely transfer of individuals who required a higher level of care transfer for services not available at the hospital. The cumulative effect of these systemic failures resulted in an immediate threat to the health and safety of all patients presenting for treatment at the Emergency Department. At approximately 1530 hours on 6/7/07, hospital administration was	A 455	The nursing shift supervisor will randomly verify that individual patients are entered into the central log. Any patient not entered into the ED central log shall be immediately entered into the central log. Reports of any variance will be recorded in the daily nursing report.	

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A 452	Continued From page 47 1530 hours on 6/7/07, hospital administration was notified of the immediate jeopardy.	A 452	Finding #5 Immediate Actions: • The emergency medicine attend (ED physician) at MLK-H will identify patients requiring neurosurgical intervention based on specific guidelines. • A protocol has been established to require that all patients with specific neurosurgical clinical condition receive timely transfer. (Attachment D). • The ED physician or the Patient Flow Manager will then contacts the MAC operator, informing him/her of the patient need transfer. • MAC determines the accepting/receiving facility based on a rotation schedule when it maintains. • MAC will contact the Patient Flow Manager at the receiving facility regarding the need for the transfer. • The Patient Flow Manager at the receiving facility promptly contacts the neurosurgeon on call and arranges the physician-to-physician contact. ED physician at MLK-H speaks directly with neurosurgeon at the receiving facility and provided a brief summary of the patient's findings. • Any clinical suggestions by the receiving neurosurgeon, which are within the capability of the hospital and the scope of practice of the ED physician, will be incorporated into the pre-transfer plan of care. • The respective facility Patient Flow Managers shall work with MAC to coordinate the transfer via ACLS transport. • All appropriate and completed documents and imaging studies shall accompany the patient. • If the ED physician determines that there is any impediment to the transfer, he/she shall contact the Chief Medical Officer at the receiving facility to facilitate the transfer. • With respect to all patient transfers, regardless of patient diagnosis, a transfer log is maintained by MLK-H Patient Flow Manager. • A multidisciplinary group meets Monday through Friday to review all transfers that have taken place based on this log, to resolve any issues identified from completed transfers, to facilitate patients waiting for transfer, and to update the statue of patients requiring transfer. Any neurosurgical patients who are pending transfer will be reviewed as part of this process. • MLK-H has identified a medical administrative Director in charge of patient flow. This Patient Flow Manager notifies the medical administrative	
A 455	482.55(a)(2) INTEGRATION OF EMERGENCY SERVICES The services must be integrated with other departments of the hospital. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the hospital failed to ensure the timely provision of emergency services to meet the needs of 20 of 68 sampled patients presenting for evaluation of an emergency medical condition. (Patients #2, #3, #5, #6, #7, #9, #15, #23, #26, #36, #49 #50, #62, #63, #64, #65, #66, #67, #68,and #69). The hospital failed to: 1. Follow their policies and procedures (P&P), by-laws, rules and regulations developed to ensure medical screening examinations were conducted by appropriately qualified individuals. 2. Ensure on - call physicians saw patients when back up specialty consultation was required. 3. Ensure pain management was provided in a timely manner, 4. Provide stabilizing treatment for emergency medical conditions. 5. Ensure timely transfer of individuals who required a higher level of care transfer for services not available at the hospital. The cumulative effect of these systemic failures resulted in an immediate threat to the health and safety of all patients presenting for treatment at the Emergency Department. At approximately 1530 hours on 6/7/07, hospital administration was	A 455		

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A 452	Continued From page 47 1530 hours on 6/7/07, hospital administration was notified of the immediate jeopardy.	A 452	Director will assure that there are impediments to transferring a patient including a neurosurgical patient, in a timely manner. The medical administrative Director will assure that there is high level physician contact with potential receiving institution in an effort to expedite transfer.	
A 455	482.55(a)(2) INTEGRATION OF EMERGENCY SERVICES The services must be integrated with other departments of the hospital. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the hospital failed to ensure the timely provision of emergency services to meet the needs of 20 of 68 sampled patients presenting for evaluation of an emergency medical condition. (Patients #2, #3, #5, #6, #7, #9, #15, #23, #26, #36, #49 #50, #62, #63, #64, #65, #66, #67, #68,and #69). The hospital failed to: 1. Follow their policies and procedures (P&P), by-laws, rules and regulations developed to ensure medical screening examinations were conducted by appropriately qualified individuals. 2. Ensure on - call physicians saw patients when back up specialty consultation was required. 3. Ensure pain management was provided in a timely manner, 4. Provide stabilizing treatment for emergency medical conditions. 5. Ensure timely transfer of individuals who required a higher level of care transfer for services not available at the hospital. The cumulative effect of these systemic failures resulted in an immediate threat to the health and safety of all patients presenting for treatment at the Emergency Department. At approximately 1530 hours on 6/7/07, hospital administration was	A 455	**Monitoring:** • The Patient Flow Manager maintains a log of patient transfers. Data regarding patient transfers is aggregated and presented to Performance Improvement Committee and to the Executive Committee, and then to the Governing Body where appropriate. **Position Responsible:** Chief Medical Officer **Permanent Action:** With respect to all patient transfers, regardless of patient diagnosis, a transfer log is maintained by MLK-H Patient Flow Manager. A multidisciplinary group meets Monday through Friday to review all transfer that have taken place based on this log., to resolve any issues identified from completed transfers, to facilitate patients waiting for transfer, and to update the status of patient requiring transfer. Any neurosurgical patients who are pending transfer will be reviewed as part of this process. MLK-H has identified a medical administrative director in charge of patient flow This Patient Flow Manager notifies Medical Administration whenever there are impediments to transferring a patient, including neurosurgical patient, in a timely manner. The medical administrative staff will assure that there is high-level physician contact with potential receiving institution in an effort to expedite transfer.	

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A 455	Continued From page 48 notified of the immediate jeopardy. Findings: 1. Patient #50 presented to the ED (emergency department) on 2/28/07 at 0950 hours, with a chief complaint of headache (comes and goes) with occasional nausea. At the time of triage, 1003 hours, the Patient described that he was experiencing severe pain, that scored nine out of 10, on a scale of one to 10, with 10 being the most severe. Patient #50 described that the pain was located at the back of his head and that it was relieved by vomiting. The patient was assigned a triage acuity of three. Per hospital policy, an acuity of three indicated the patient had a major illness or injury, but was stable. At 1250 hours, Patient #50 was taken to the treatment area. Nursing assessment at that time revealed " steady gait " , pupil sizes of 33 and 31 mm. A Glascow Coma Scale score of 15 was recorded (a standardized series of observations reflecting speech, pain, orientation and speech. A score of 15 is normal). Patient #50 was assessed by the emergency department physician, at which time "paraspinal tenderness" was noted, but no " Neuro" changes or " Psych" abnormalities recorded. A blood count revealed 16.4 gms. of hemoglobin and a white count of 10,800 (upper normal range). Morphine 4 mg was administered in the emergency department, however, the results of the medication administration was not recorded. A CT head scan was ordered by the ED physician. At 1550 hours Patient #50 was taken to CT. The	A 455	Patient #50 - Immediate Actu • ED nurse manager counseled the RN who gave morphine 4mg, but did not receive the results of the medication administration. • ED nurse manager educated all ED registered nurses on the requirements to record the results of medication administration. (Attachment N) **Permanent Actions:** The monitoring processes described below will be used to assure the continuing effectiveness of the corrective actions. **Monitoring:** Quality Improvement will review ten randomly selected charts weekly to assess documentation of results of pain medication. Deficiencies will be addressed by the ED Nurse manager. Data from these reviews will be presented to the Performance Improvement Committee and to the Executive Committee. **Responsible Position:** Chief Nursing Officer ED Nurse Manager **Immediate Actions:** • A protocol has been established to require that all patient with specific neurosurgical clinical conditions receive timely transfer. (Attachment I) • The emergency medicine attending physician at MLK-H will identify patient requiring neurosurgical intervention based on specific guidelines. • The Ed physician or the Patient Flow Manager will than contact the MAC operator, informing him/her of the patient needing transfer. • MAC determines the accepting/receiving facility based on a rotation scheduled when it maintains. • The Patient Flow Manager at the receiving facility promptly contacts the neurosurgeon on call and arranges the physician-to-physician contact. ED physician t MLK-H speaks directly with neurosurgeon at the receiving facility and provided a brief summary of the patient's findings. • Any clinical suggestion by the receiving neurosurgeon, which are within the capability of the hospital and the scope of practice of the ED physician, will be incorporated into the pre-transfer plan of care.	6/19/07 6/15/07

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A 455	Continued From page 49 report revealed, "significant ventricular dilatation with periventricular changes consistent with subependymal edema. This may be related to a heterogeneous mass near the region of the pineal with caudal extension to a level near the proximal fourth ventricle." The scan revealed a brain tumor measuring approximately 2.5 cm. compressing the internal circulation of fluid in the brain resulting in internal swelling from dilatation of the ventricular system of the brain. An MRI image of the brain was recommended and completed. This confirmed the presence of a tumor mass in the region of the pineal gland. Moderate dilatation of the ventricular system of the brain was noted. A handwritten note by the ED physician stated that Neurosurgery services were not available at the hospital, "will arrange MAC transfer." (The MAC is the medical alert center for Los Angeles County. This is the central clearing house for all Los Angeles County hospitals.) There was no written documentation that physician to physician contact had been initiated. A clinical impression of "Acute Obstructive Hydrocephalus" was recorded. A physician order for a neurosurgery consult was written at 1653 hours on 2/28/07. A "Neurology Consultation" hand written by a Physician Assistant (PA-C). identified that the patient was seen for evaluation at 1720 hours. The consultation revealed no neurological defects or alteration in mental status for Patient #50. The consult described symptoms of dizziness, nausea, headache and vomiting. The consultation, provided by the PA-C, was then countersigned by the attending neurology physician at 1900 hours. No written note was provided by the neurology physician. The medical	A 455	• The neurologist in addition to co-signing the consultation wrote comments and recommendations on the consultation form. Background: The Medical Alert Center (MAC) coordinates transfe of patients from MLK-H to other facilities. The MAC receives clinical data regarding the patient, and the MLK-H Patient Flore Manager (or where appropriate, the physician) presents additional clinical data to the receiving. In this instance, there were no available neurosurgical beds within the County. The MAC continued efforts to locate an appropriate placement however, an appropriate placement could not be found before the patient left AMA. Immediate Actions: • The emergency medicine attending (ED physician) at MLK-H will identify patients requiring neurosurgical intervention based on specific guidelines. • A protocol has been established to require that all patients with specific neurosurgical clinical conditions receive timely transfer (Attachment D). • The ED physician or the Patient Flow Manager will then contact the MAC operator, informing him/her of the patient needing transfer.	

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A 455	Continued From page 50 record failed to contain documented evidence that the neurologist had actually examined Patient #50. This finding was in violation of the Medical Staff rules and regulations requiring a written note. The consultation request form revealed that "Stat MAC transfer to a facility with neurosurgical service" was required. A written order for MAC transfer to Neurosurgical facility was provided at 1717 hours by the attending ED physician. There was, however, no written documentation that any physician had actually spoken with or discussed the emergent clinical situation of Patient #50 with a proposed receiving hospital to facilitate transfer for Patient #50. Documents contained in the medical record revealed that Patient #50 signed a transfer consent on 2/28/07. At 0350 hours on March 1, 2007, nursing notes revealed that Patient #50 was administered Dilaudid (narcotic pain medication) by IVP (intravenously push). There was no documented evidence that a ED physician had examined or assessed the neurological status of Patient #50. A nursing re-assessment performed at 0550 hours revealed that a neurocheck had been performed and the headache pain of Patient #50 had improved. Additional nursing assessments were performed at 0730, 0900,1100, 1300, 1500, and 1830 hours. These nursing assessments documented no change in the status of Patient #50 These assessments indicated that Patient #50 was able to move all four extremities and remained alert. No physician assessments were documented. Patient #50 remained in the ED until 3/3/07.	A 455	The respective facility Patient Flow Managers shall work with MAC to coordinate the transfer via ACLS transport. All appropriate and completed documents and imaging studies shall accompany the patient. If the ED physician determines that there is ANY impediment to the transfer, he/she shall contact the Chief Medical Officer at the receiving facility to facilitate the transfer. **Permanent Actions:** With respect to all patient transfers, regardless of patient diagnosis, a transfer log is maintained by MLK-H Patient Flow Manager. A multidisciplinary group meets Monday through Friday to review all transfers that have taken place based on this log, to resolve any issues identified from completed transfers, to facilitate patients waiting for transfer, and to update the status of patients requiring transfer. Any neurosurgical patients who are pending transfer will be reviewed as part of this process. MLK-H has identified a Medical Administrative Director in charge of patient flow. This Patient Flow Manager notifies the Medical Administrative Director whenever there are impediments to transferring a patient, in a timely manner. The Medical Administrative Director will assure that there is high level physician contact with potential receiving institutions in an effort to expedite transfer. **Monitoring:** The Patient Flow Manager maintains a log of patient transfers. Data regarding patient transfers is aggregated and presented to Performance Improvement Committee and to the Executive Committee, and then to the Governing Body, where appropriate. **Responsible Position:** Interim Chief Medical Officer	

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A 455	Continued From page 51 Review of the medical record revealed that the patient was assessed by nursing staff and continued to received Dilaudid and morphine to control his headache pain. The nursing pain assessments included only a numerical score to identify the intensity of pain but failed to identify pain radiation, quality (ache, throbbing, sharp, dull, burning) and constancy, as required by established hospital policy. The medical record failed to provide documented evidence that ED physicians provided on-going assessments and care. Except for the initial consult, the neurologist did not see the Patient #50 again. On 3/3/07 at 0725 hours, nursing documentation identified that Patient #50 complained of occipital headache pain. Intensity of pain was recorded as 5/10. The patient was not given pain medication nor were non-medication interventions provided. Nursing documentation further identified that no deficits were noted. However, the very next sentence stated c/o (complaint of) blurred vision when ambulating. The patient was not evaluated for the neurological symptom by a physician. At 1100 hours, Patient #50 complained of increased head pain. The patient identified the intensity of pain as being 9/10 (severe). The patient received Dilaudid 1 mg. IV for pain. Although a physician order was obtained for the pain medication, the patient's medical record failed to contain documented evidence that the ED physician evaluated the patient. At 1150 hours, Patient #50 and his family indicated that after three days, they were tired of waiting for transfer to another hospital. Patient #50 signed out AMA (against medical advise) to seek treatment elsewhere. The "Leaving Hospital	A 455	Immediate Actions: • The Interim Chief Medical Officer ordered all MLK Department Chiefs to discontinue the practice of using Physician Assistants for consultations in the ED. All ED consultations will be performed by an attending physician. (Attachment BB) • The ED Nurse Manager provided a letter instructing all Ed RN's regarding Physician Assistants cannot provide consults. (Attachment J) • The Interim Chief Medical Officer instructed all Department Chiefs to ensure that all attending physicians are aware of the need to document their consultations (Attachment BB) Permanent Action: The monitoring described below will be used to assure the continuing effectiveness of these correction actions. Position Responsible: Interim Chief Medical Officer Immediate Actions: • ED nurse manager counseled the RN who gave morphine 4mg, but did not receive the results of the medication administration. • ED nurse manager educated all ED registered nurses on the requirements to record the results of medication administration. (Attachment H)	6/14/07 6/19/07 6/19/07 6/19/07 6/15/07

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A 455	Continued From page 52 against Medical Advice" form was noted to be incomplete. In addition, the medical record failed to contain documented evidence that at the time of discharge, Patient #50 had been assessed by a physician or had received discharge instructions. On 6/1/07 and 6/5/07 discussions with hospital staff regarding the care of Patient #50 and quality assurance, identified that the medical care received by Patient #50 was deemed to be appropriate. The hospital was requested to provide any and all documentation related to the patient's care as well as any quality of care reviews. A case review summary for Patient #50 was received at 1340 hours on 6/5/07. The case review confirmed a failure of the ED physicians to document assessments of Patient #50 for three days. Further review of the summary identified that there was a county system - wide plan to provide neurosurgical services and to streamline the transfer process of patients between hospitals. Patient #50 was a pending transfer to a higher level of care on 3/3/07 prior to leaving the hospital against medical advice. As of 6/7/07, the county system - wide plan to ensure the prompt provision of adequate neurosurgical care had not been implemented. 2. Patient #69 presented to the emergency department on 3/8/07 at 2242 hours, with a chief complaint of stomach pain for the past two weeks. The nurse documented that the pain was in all four quadrants and radiated in to the patient's back. It was documented that the patient had multiple episodes of nausea and vomiting today. Patient #69 identified her pain as being	A 455	mmediate Actions – Patient 50 • The ED Medical Director provided education for all ED physicians on "change of shift and patient hand-off recommendations." This directive requires specific acknowledgement and documentation of the hand-offs on each shift (Attachment K). • A hospitalist position on all shifts was added to the Emergency Department team to assume responsibility for the care of internal medicine patients who are admitted to MLK-H, the hospitalist assumes responsibility for facilitating the transfer. While the patient is awaiting transfer or admission, the hospitalist assumes responsibility for facilitating the transfer. While the patient is awaiting transfer or admission, the hospitalist is responsible for writing holding orders, reassessing the patient periodically, and modifying the plan of care as required. However, the ED physicians remain responsible for neurosurgical, orthopedic and psychiatric patients awaiting transfer and other departments would assume responsibility for their patients. • For the ED physicians, the smart chart (a physician documentation record, which is a tool, used to assure consideration of important clinical questions) was implemented to improve physician documentation and to capture encounter times. • The ED Medical Director informed ED physicians at a department meeting, and followed-up with a written directive to all ED physicians, that they were responsible for assessing all active patients and patients waiting for transfer at the beginning of each shift. They were also informed of their responsibility to meet with oncoming physicians at the end of shift to provide appropriate information as part of the pass on process. Physicians were also reminded to document the patient's condition at change of shift and to document that the patient's care was transferred to the oncoming physician by name (Attachment K).	6/9/07 3/07 3/07 6/9/07

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A 455	Continued From page 52 against Medical Advice" form was noted to be incomplete. In addition, the medical record failed to contain documented evidence that at the time of discharge, Patient #50 had been assessed by a physician or had received discharge instructions. On 6/1/07 and 6/5/07 discussions with hospital staff regarding the care of Patient #50 and quality assurance, identified that the medical care received by Patient #50 was deemed to be appropriate. The hospital was requested to provide any and all documentation related to the patient's care as well as any quality of care reviews. A case review summary for Patient #50 was received at 1340 hours on 6/5/07. The case review confirmed a failure of the ED physicians to document assessments of Patient #50 for three days. Further review of the summary identified that there was a county system - wide plan to provide neurosurgical services and to streamline the transfer process of patients between hospitals. Patient #50 was a pending transfer to a higher level of care on 3/3/07 prior to leaving the hospital against medical advice. As of 6/7/07, the county system - wide plan to ensure the prompt provision of adequate neurosurgical care had not been implemented. 2. Patient #69 presented to the emergency department on 3/8/07 at 2242 hours, with a chief complaint of stomach pain for the past two weeks. The nurse documented that the pain was in all four quadrants and radiated in to the patient's back. It was documented that the patient had multiple episodes of nausea and vomiting today. Patient #69 identified her pain as being	A 455	An outside consultant provided reinforcing education to all ED nursing leadership on the importance of patient advocacy, particularly as it relates to chair of command and nurse-to-physician communication. Permanent Action: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. Monitoring: Ten charts will be randomly reviewed each week to validate the documentation of physician involvement at the change of shift and hospitalist involvement with patient's awaiting admission or transfer. Deficiencies will be addressed with the department chair. Results of these audits will be provided to the Performance Improvement Committee, which will review and create corrective action as necessary. This data will then be reported to Executive Committee and to the Governing Body as appropriate. Positions Responsible: Chair, Department of Internal Medicine ED Medical Director Immediate Actions – Patient 50: • The ED Medical Director provided education for all ED physicians on "change of shift and patient hand-off recommendations." This directive requires specific acknowledgement and documentation of the hand-offs on each shift (Attachment K). • A hospitalist position on all shifts was added to the Emergency Department team to assume responsibility for the care of internal medicine patients who are admitted to MLK-H, the hospitalist assumes responsibility for facilitating the transfer. While the patient is awaiting transfer or admission, the hospitalist assumes responsibility for facilitating the transfer. While the patient is awaiting transfer or admission, the hospitalist is responsible for writing holding orders, reassessing the patient periodically, and modifying the plan of care as required. However, the ED physicians remain responsible for neurosurgical, orthopedic and psychiatric patients awaiting transfer and other departments would assume responsibility for their patients.	6/9/07 3/07

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LAC/MARTIN LUTHER KING JR GEN HOSPITAL	12021 S WILMINGTON AVE LOS ANGELES, CA 90059

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A 455	Continued From page 52 against Medical Advice" form was noted to be incomplete. In addition, the medical record failed to contain documented evidence that at the time of discharge, Patient #50 had been assessed by a physician or had received discharge instructions. On 6/1/07 and 6/5/07 discussions with hospital staff regarding the care of Patient #50 and quality assurance, identified that the medical care received by Patient #50 was deemed to be appropriate. The hospital was requested to provide any and all documentation related to the patient's care as well as any quality of care reviews. A case review summary for Patient #50 was received at 1340 hours on 6/5/07. The case review confirmed a failure of the ED physicians to document assessments of Patient #50 for three days. Further review of the summary identified that there was a county system - wide plan to provide neurosurgical services and to streamline the transfer process of patients between hospitals. Patient #50 was a pending transfer to a higher level of care on 3/3/07 prior to leaving the hospital against medical advice. As of 6/7/07, the county system - wide plan to ensure the prompt provision of adequate neurosurgical care had not been implemented. 2. Patient #69 presented to the emergency department on 3/8/07 at 2242 hours, with a chief complaint of stomach pain for the past two weeks. The nurse documented that the pain was in all four quadrants and radiated in to the patient's back. It was documented that the patient had multiple episodes of nausea and vomiting today. Patient #69 identified her pain as being	A 455	Immediate Actions – Patient 50 • The ED Nurse Manager provided education for all ED RNs on discharge assessments. • The ED Medical Director provided education to ED MDs on the elopement and AMA policy, which includes the requirement to document the patient's level of capacity and the discussion with the patient regarding the risks and benefits. The education addressed that patients should be provided with instructions for follow-up care (Attachment M). Permanent Action: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. Monitoring: Ten randomly selected charts will be reviewed each week to validate completion of discharge assessments by MDs and RNs. Deficiencies will be discussed with the appropriate supervisor and results will be reported to Performance Improvement Committee, which will review and create corrective action as necessary. This data will then be reported to the Executive Committee and to the Governing Body as appropriate. Position Responsible: ED Nurse Manager ED Medical Director Immediate Actions – Patient 69: • The ED Nurse Manager will provide re-education to all ED RNs on the requirements to classify patients into a triage category that is consistent with their presentation (Attachment O).	6/5/07 6/21/07

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A 455	Continued From page 53 severe with a score of 10 out of 10. Patient #69 identified that the pain she was experiencing was constant and that nothing provided relief. The pain was further described as aching and burning with a pressure sensation. Nursing documentation revealed that the patient was moaning and had facial grimacing. Vital signs were recorded as Temperature 102.8 degrees, heart rate 97, respirations 24 and blood pressure was 133/59. No treatment was provided to alleviate pain or reduce the patient's fever at the time of triage. The patient was assigned a triage category of 3. Category or Level 3 patients are described as having a stable major injury or illness. Two hours later, at 0040 hours, Patient #69's vital signs were re-assessed. Patient #69 had a temperature of 102.4 degrees, heart rate 102, respirations 20 and blood pressure was recorded as 118/62. The patient continued to experience severe abdominal pain. No treatments were provided in the triage area. At 0110 hours, the patient was transferred to the treatment area. Patient #69 continued to have severe pain, recorded as 7/10. The patient received Tylenol 650 mg. and was placed on oxygen by mask. At 0220 hours, the patient was described to have decreased pain. At 0400 hours, nursing documentation revealed that Patient #69 had no orders for care and was waiting for the physician assistant. This was approximately three hours after she was taken to the treatment area of the ED. Patient #69 was not evaluated by a physician until 0530 hours The patient was described as having a fever and was in moderate to severe distress.	A 455	**Immediate Actions – Patient 69 (cont'd)** • The ED Nurse Manager provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain at a level, which requires intervention based on the pain policy. This information must be documented in the patient's medical record (Attachment H). • A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triaging process was re-designed to provide for a more timely medical screening exam. This process includes the following (Attachment O). o The triage nurse and registration clerk are co-located so that the triaging process and the registration process can occur simultaneously. o A physician will be available to the triaging area to perform immediate medical screening examinations for patients who are identified as a Level 3. Upon completion of the medical screening examination, based on the patient's clinical presentation, tests and treatments (including pain management) will be ordered and carried out. o Patients who are identified as a Level 1 and 2 at the time of triage will be brought back to the emergency treatment area. At the time of arrival, the ED charge nurse will notify the physician of the patient's arrival by placing the patient's pseudo name on the white board along with the patient's priority number. The physician will acknowledge the patient by initialing the white board and will perform the medical screening examination as soon as possible, if a patient's condition is critical, the RN will verbally notify the physician.	

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A 455	Continued From page 54 The patient continued to experience severe pain and nausea. The patient experienced severe pain throughout her ED stay. At 0950 hours, 11 hours after presenting to the ED, the patient was transferred to surgery services to undergo an exploratory laparotomy. 3. The medical record for Patient #26 documented the teenager presented to the emergency department (ED) at 2355 hours on 2/12/07 with right abdominal pain. He was triaged by the nurse and determined to have pain of 10 on a 1-10 scale (10/10). His oxygen saturation level was 100%, his pulse 95 respirations were 18 and his blood pressure was 113/69. At 0040 hours the nurse documented the patient was complaining of difficulty breathing. The nurse documented he had wheezing in his lungs, his respiratory rate was 22 , blood pressure was 135/70, oxygen saturation was 97% and that he was anxious and restless. There was no documentation about why he was left in the lobby of the ED. No pain medication or other pain relieving interventions were provided. There was no re-assessment of the patient until he was taken to a treatment area five hours later. At 0530 hours on 2/13/07 his pain was 8/10. At 0645 hours laboratory tests and pain medication were ordered for Patient #26. The pain medication was administered at 0840 hours; approximately 8 and 1/2 hours after he presented to the ED. Laboratory test results were not available until 2100 hours. This was approximately 14 hours after they were ordered and 19 hours after Patient #26 came to the ED. There was no documented evidence the nursing or medical staff were following-up to ensure the laboratory test results were obtained. During	A 455	**Permanent Action:** The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. **Monitoring:** Ten randomly selected medical records will be reviewed daily to track the time from triage to medical screening examination. Data from these daily reviews will be presented to the ED Collaborative Practice Committee and the process will be re-evaluated as a result of this review. Data will also be presented to the Performance Improvement Committee monthly which will evaluate it, create corrective actions as necessary, and report it to the Executive Committee and as appropriate, the Governing Body. **Position Responsible:** ED Medical Director ED Nurse Manager **Immediate Actions – Patient 26:** • The ED Nurse Manager provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain, which requires interventions based on the pain policy (Attachment H). • A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triaging process was re-designed to provide for a more timely medical screening examination. This process includes the following: o The triage nurse and registration clerk are co-located so that the triaging process and the registration process can occur simultaneously. o A physician will be available to the triaging area to perform immediate medical screening examination, based on the patient's clinical presentation, tests and treatments (including pain management) will be ordered and carried out.	5/19/07

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A 455	Continued From page 55 interviews on 6/1/07 medical staff stated this patient "fell through the cracks." 4. a. The medical record for pediatric Patient #36 showed she presented to the emergency department at 1030 hours on 3/20/07 for vomiting, lethargy, cough and congestion. She had a history of a ventriculoperitoneal shunt for hydrocephalus and began to feel bad after a visit to the dentist. Documentation shows the presence of a shunt malformation and/or infection was being ruled out. A neurology consult was ordered. At 1230 the physician's assistant (PA-C) saw the patient to perform the neurology consultation. There was no documented evidence a neurologist saw the patient; however, the PA-C documented the recommended plan, in consultation with the neurologist, would be evaluation and management by a neurosurgeon on an urgent basis to assess the functioning of the shunt. Since neurosurgeons were not available at the hospital the PA-C recommended transfer to another hospital. The child was in the emergency department until 2200 hours but there was no documented evidence a neurosurgeon was contacted or that efforts were made to transfer the patient to a hospital with this service available. The patient was discharged to the mother's care. Interviews conducted with the Medical Director of the hospital on 06/01/2007 and a review of an administrative document of 03/07/2007 and 03/12/2007, revealed that Neurosurgical back up specialty coverage had been scheduled to terminate on 02/28/2007. However, arrangements had been made to extend Neurosurgical coverage by staff neurosurgeons " through 04/2007. " Medical staff interviews revealed that the emergency department physicians were not informed that	A 455	Immediate Action – Patient 36; • The Interim Medical Director directed the chairs of the Department of Medicine, Women's and Child health and Surgery that physician assistants will no longer be conducting medical consultations in the ED (Attachment BB). • It was determined that there was no longer a need for neurosurgical transfer based on the results on the shunt series, but this was not clearly documented. The Chair of Department of Women's and Child's health will counsel this physician on the lack of clear documentation of the change in treatment plan. Permanent Action: The monitoring process described below will be used to assure the effectiveness of these corrective actions. Monitoring: Ten randomly selected ED records of patients who received a consult, including those who received consults on the weekends will be reviewed each week to validate that all consults were performed by a physician and that there is a consulting physician's note. The Chair of responsible department will be notified of discrepancies for corrective actions. Results of these audits will be presented to Performance Improvement Committee, which will review and create corrective action as necessary. The data will then be reported to Executive Committee: Positions Responsible: ED Medical Director Interim Chief Medical Director	

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A 455	Continued From page 56 contractural coverage had been extended and available. 4. b. At 1215 hours on 3/20/07 radiological tests of Patient #36's shunt was ordered. Documentation shows the patient went to x-ray at 1325 hours ,but the tests were not performed because the radiology department did not know what to do. At 1415 hours the patient was again sent to the radiology department for the tests. The test results were not available for diagnosis and/or treatment until 1700 hours; 6 and 1/2 hours after Patient #36 presented to the ED. 5. The medical record for Patient #5 documented he presented to the ED at 1139 hours on 5/11/07 with left flank pain. He was not seen by a triage nurse until three hours later, to determine the severity of his symptoms. At 1448 hours, the triage nurse documented his pain was 8/10. At 1730 hours the nurse documented the first full assessment of the patient. The patient was evaluated by a physician's assistant. There was no documented evidence a physician saw Patient #5. Pain medication was not administered to Patient #5 until 2100 hours, 9 and 1/2 hours after he presented to the ER. No further treatment was provided to Patient #5 and it was documented that he eloped from the ED at 0000 hours on 5/12/07. 6. The medical record for Patient #6 identified that he came to the ED at 1812 hours on 5/11/07 for a "surgical consult for (his) umbilical hernia." He was triaged at 1845 hours, and complained of 5/10 pain. When he was called to the treatment area, four hours later, he did not answer. At 0100 hours the nurse documented Patient #6 left without being seen. No medical screening	A 455	Immediate Action – Patient 36; The Interim Medical Director directed the chairs of the Department of Medicine, Women's and Child health and Surgery that physician assistants will no longer be conducting medical consultations in the ED (Attachment BB). It was determined that there was no longer a need for neurosurgical transfer based on the results on the shunt series, but this was not clearly documented. The Chair of Department of Women's and Child's health will counsel this physician on the lack of clear documentation of the change in treatment plan. Permanent Action: The monitoring process described below will be used to assure the effectiveness of these corrective actions. Monitoring: Ten randomly selected ED records of patients who received a consult, including those who received consults on the weekends will be reviewed each week to validate that all consults were performed by a physician and that there is a consulting physician's note. The Chair of responsible department will be notified of discrepancies for corrective actions. Results of these audits will be presented to Performance Improvement Committee, which will review and create corrective action as necessary. The data will then be reported to Executive Committee: Positions Responsible: ED Medical Director Interim Chief Medical Director	

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A 455	Continued From page 56 contractural coverage had been extended and available. 4. b. At 1215 hours on 3/20/07 radiological tests of Patient #36's shunt was ordered. Documentation shows the patient went to x-ray at 1325 hours ,but the tests were not performed because the radiology department did not know what to do. At 1415 hours the patient was again sent to the radiology department for the tests. The test results were not available for diagnosis and/or treatment until 1700 hours; 6 and 1/2 hours after Patient #36 presented to the ED. 5. The medical record for Patient #5 documented he presented to the ED at 1139 hours on 5/11/07 with left flank pain. He was not seen by a triage nurse until three hours later, to determine the severity of his symptoms. At 1448 hours, the triage nurse documented his pain was 8/10. At 1730 hours the nurse documented the first full assessment of the patient. The patient was evaluated by a physician's assistant. There was no documented evidence a physician saw Patient #5. Pain medication was not administered to Patient #5 until 2100 hours, 9 and 1/2 hours after he presented to the ER. No further treatment was provided to Patient #5 and it was documented that he eloped from the ED at 0000 hours on 5/12/07. 6. The medical record for Patient #6 identified that he came to the ED at 1812 hours on 5/11/07 for a "surgical consult for (his) umbilical hernia." He was triaged at 1845 hours, and complained of 5/10 pain. When he was called to the treatment area, four hours later, he did not answer. At 0100 hours the nurse documented Patient #6 left without being seen. No medical screening	A 455	Immediate Actions – Patient 6: A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process includes the following: o The triage nurse and registration clerk are co-located so that the triaging process can occur simultaneously. o A physician will be available to the triaging area to perform immediate medical screening examinations for patients who are identified as a Level 3. Upon completion of the medical screening examination, based on the patient's clinical presentation, tests and treatments (including pain management) will be ordered and carried out. o Patients who are identified as a Level 1 and 2 at the time of triage will be brought back to the emergency treatment area. At the time of arrival, the ED charge nurse will notify the physician of the patient's arrival by placing the patient's pseudo name on the white board along with the patient's priority number. The physician will acknowledge the patient by initialing the white board and will perform the medical screening examination as soon as possible. If a patient's condition is critical, the RN will verbally notify the physician.	

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	050578	A. BUILDING _____ B. WING _____	06/07/2007

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A 455	Continued From page 57 examination had been performed to determine if the patient had a medical emergency condition. 7. The medical record for Patient #7 showed she presented to the ED at 2045 hours on 5/11/07 for "spotting" during her pregnancy. Patient #7 stated she was 2 months pregnant. At 2140 hours she was triaged and a pregnancy test was documented as positive. When the patient was called to the treatment area 2 hours later, she had left without being seen to determine if an emergency condition existed. Patient #7 returned to the ED at 1306 hours on 5/14/07 with a complaint of vaginal bleeding for three days. She had 8/10 pain when triaged by the nurse at 1315 hours. There was no documented evidence the ED nurse evaluated how much the patient was bleeding. There was no documented re-assessment of her condition, until she was taken to the treatment area, four hours later, at 1730 hours. No pain medication/intervention was given. Her medical screening exam was conducted by a PA-C. She passed the products of conception while having an ultrasound done, and was discharged by a physician at 2235 hours, after having had a miscarriage. 8. Patient #2 came to the ED of the hospital on 4/30/07 at approximately 1207 hours. When triaged at 1250 hours, she identified she had sharp pain of 10 on a 1-10 scale, with 10 being the most severe. No pain interventions were initiated in the triage area. The patient was taken to the treatment area five hours later at 1815 hours, and received pain medication one hour later. Approximately 20 hours after she presented to	A 455	Once audits demonstrate consistency, monitoring will be limited to ten charts monthly. Immediate Actions – Patient 2: • The ED Nurse Manger provided re-education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain which requires intervention based on the pain policy. This information must be documented in the patient's medical record (Attachment H). • A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triaging process was re-designed to provide for a more timely medical screening examination. This process includes the following : (Attachment O) o The triage nurse and registration clerk are co-located so that the triaging process and the registration process can occur simultaneously. o A physician will be available to the triaging area to perform immediate medical screening examinations for patients who are identified as a level 3. Upon completion of the medical screening examination, based on the patient's clinical presentation, tests and treatments (including pain management) will be ordered and carried out. Immediate Actions – Patient 7: • A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triaging process was re-designed to provide for a more timely medical screening examination. This process includes the following: o The triage nurse and registration clerk are co-located so that the triaging process and the registration process can occur simultaneously. o A physician will be available to the triaging area to perform immediate medical screening examinations for patients who are identified as a Level 3. Upon completion of the medical	6/19/07

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A 455	Continued From page 57 examination had been performed to determine if the patient had a medical emergency condition. 7. The medical record for Patient #7 showed she presented to the ED at 2045 hours on 5/11/07 for "spotting" during her pregnancy. Patient #7 stated she was 2 months pregnant. At 2140 hours she was triaged and a pregnancy test was documented as positive. When the patient was called to the treatment area 2 hours later, she had left without being seen to determine if an emergency condition existed. Patient #7 returned to the ED at 1306 hours on 5/14/07 with a complaint of vaginal bleeding for three days. She had 8/10 pain when triaged by the nurse at 1315 hours. There was no documented evidence the ED nurse evaluated how much the patient was bleeding. There was no documented re-assessment of her condition, until she was taken to the treatment area, four hours later, at 1730 hours.. No pain medication/intervention was given. Her medical screening exam was conducted by a PA-C. She passed the products of conception while having an ultrasound done, and was discharged by a physician at 2235 hours, after having had a miscarriage. 8. Patient #2 came to the ED of the hospital on 4/30/07 at approximately 1207 hours. When triaged at 1250 hours, she identified she had sharp pain of 10 on a 1-10 scale, with 10 being the most severe. No pain interventions were initiated in the triage area. The patient was taken to the treatment area five hours later at 1815 hours, and received pain medication one hour later. Approximately 20 hours after she presented to	A 455	○ screening examination, based on the patient's clinical presentation, tests and treatments (including pain management) will be ordered and carried out. ○ Patients who are identified as a Level 1 and 2 at the time of arrival, the ED charge nurse will notify the physician of the patient's arrival by placing the patient's pseudo name on the white board along with the patient's priority number. The physician will acknowledge the patient by initialing the white board and will perform the medical screening examination as soon as possible. If a patient's condition is critical, the RN will verbally notify the physician. • The ED Nurse Manager counseled the registered nurse who did not evaluate the amount of bleeding. • The Chief Medical Officer notified the ED Medical Director that physician assistants shall no longer perform medical screening examinations. (Attachment B) • The EDMedical Director informed each Physician Assistant by e-mail that they may no longer perform medical screening examination. (Attachment C) Monitoring: • The Ed Nurse Manager or designee will review ten randomly selected charts each week to assess ED patients for appropriateness of pain intervention based on pain score. Deficiencies will be addressed by the ED Nurse Manager. Data from the weekly reviews will be presented to the ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary and report it t Quality Council and Executive Committee, and as appropriate to the Governing Body. Once audits demonstrate consistency, monitoring will be limited to ten charts monthly. Position Responsible: ED Medical Director ED Nurse Manager Chief Medical Officer	6/21/07 6/21/07 6/8/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 455	Continued From page 58 the ED, at 0830 hours on 5/1/07, a general surgery consultation was provided to evaluate the acute abdominal pain for Patient #2. The closed medical record for Patient #2 revealed "Dr."at bedside. However, review of the record revealed that the general surgery consultation had been provided by a Physician Assistant (PA-C). 9. Patient #23 came to the emergency department on 4/30/07 at approximately 1000 hours, for the evaluation of a known ectopic pregnancy. At 1800 hours a nursing interval note indicated that the emergency department was unable to admit Patient #23 to the hospital "due to short staff." There was no nursing or physician documentation to indicate intervention to evaluate the appropriate provision of care for Patient #23. The patient was admitted to an in-patient bed at 2100 hours. 10. Patient #3 came to the emergency department of the hospital at approximately 2040 hours on 4/30/07. Patient #3 stated that he was seeing aliens and devils. He was dropped off by his family. At triage the nurse documented the patient had suicidal ideations with a plan to drink bleach. The nurse triaged the patient as a category 3 (stable major illness) and left him in the lobby for over one hour before taking him back to the treatment area. Patient #3 was evaluated by the emergency department physician at 0500 hours on 5/1/07, a delay of almost 7 hours. No psychiatric treatment or consultation was provided. Approximately 6 hours later, at 1055 hours on 5/1/07, an evaluation by a mental health professional was requested.	A 455	**Patient 23** **Immediate Action – Pate #3:** •• A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triaging process was re-designed to *provide for a timely medical screening* examination. This process includes the following:(Attachment O) o The triage nurse and registration clerk are co-located so that the *triaging process can occur* simultaneously. o A physician will be available to the triaging area to perform immediate medical screening *examinations for patients who* are identified as a level 3. Upon completion of the medical screening examination, based on the patient's clinical presentation, tests and treatments (including pain management) will be ordered and carried out. o Patients who are identified as a level 1 and 2 at the tie of triage will be brought back to the emergency treatment area. At the time of arrival, the ED charge nurse will notify the physician of the patient's arrival by placing the patient's pseudo name on the white board along with the patient's priority number. The physician will acknowledge the patient by initialing the white board and will perform the medical screening examination as soon as possible. If a patient's condition is critical, the RN will verbally notify the physician.	

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A 455	Continued From page 58 the ED, at 0830 hours on 5/1/07, a general surgery consultation was provided to evaluate the acute abdominal pain for Patient #2. The closed medical record for Patient #2 revealed "Dr." at bedside. However, review of the record revealed that the general surgery consultation had been provided by a Physician Assistant (PA-C). 9. Patient #23 came to the emergency department on 4/30/07 at approximately 1000 hours, for the evaluation of a known ectopic pregnancy. At 1800 hours a nursing interval note indicated that the emergency department was unable to admit Patient #23 to the hospital "due to short staff." There was no nursing or physician documentation to indicate intervention to evaluate the appropriate provision of care for Patient #23. The patient was admitted to an in-patient bed at 2100 hours. 10. Patient #3 came to the emergency department of the hospital at approximately 2040 hours on 4/30/07. Patient #3 stated that he was seeing aliens and devils. He was dropped off by his family. At triage the nurse documented the patient had suicidal ideations with a plan to drink bleach. The nurse triaged the patient as a category 3 (stable major illness) and left him in the lobby for over one hour before taking him back to the treatment area. Patient #3 was evaluated by the emergency department physician at 0500 hours on 5/1/07, a delay of almost 7 hours. No psychiatric treatment or consultation was provided. Approximately 6 hours later, at 1055 hours on 5/1/07, an evaluation by a mental health professional was requested.	A 455	Permanent Actions: • The monitoring process described below will be used to monitor the effectiveness of corrective actions: Monitoring: • Starting July 1, 2007, Utilization Review Staff will review at least 15% of patients weekly to track and trend data from arrival to triage and arrival to medical screening exam. Time of arrival to time of discharge is tracked electronically through the Affinity System for all patients and trended weekly. The information goes to the Emergency Department Collaborative Committee for evaluation. The reports will go to both the ED Committee and the Quality/Performance Improvement Committee (QPIC), which will report this to the Executive Committee or Quality Counsel respectively, and then to the Governing Body. Immediate Actions: • Effective 5/29/07 the policy entitled Management of Psychiatric patients #118 for the Emergency Department was revised to address the needs of psychiatric patients presenting to the MLK-H emergency department. To assure that there was compliance with the revised policy, the ED Nurse Manager completed inservice on the revised policy with emphasis that at no time should the patient be left alone. Permanent Action: • The monitoring process described below will be used to assure the effectiveness of the corrective actions. Monitoring: • The ED Nurse Manager or designee will review ten randomly selected charts each week to assess for appropriateness of triage acuity score based on the Emergency Severity Index; this includes psychiatric patients. The ED Nurse Manager will address deficiencies with responsible individuals. Data from the weekly reviews will be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary, and report it to Quality Council, Executive Committee and the Governing Body. Once audits demonstrate consistency, monitoring will be limited to ten charts monthly.	

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A 455	Continued From page 59 The mental health evaluation was not completed, until four hours later at 1500 hours; 17 hours after he presented to the ED. The mental health professional determined the patient denied being suicidal at the time of the evaluation. Patient #3 was discharged home at 2100 hours without receiving treatment. 11. Patients #62, #63, #64, #65, #66, #67, #68 were triaged on 5/30 and/or 5/31/07 and sent to the Urgent Care area of the emergency department. Each patient was examined and treated by a Physician Assistant, PA-C. When reviewed, each medical record revealed that the patients had been evaluated, treated and discharged from the urgent care of the hospital prior to the time of supervision or monitoring by the emergency department physician. The medical record for each patient failed to demonstrate a timed entry by the emergency department physician. When interviewed on 5/31/07 at approximately 1030 hours, the PA-C readily admitted that medical screening examinations, provided by the PA-C, were unsupervised by a physician. Patients were evaluated, treated and discharged from the urgent care area prior to the medical record being evaluated by a physician. When reviewed, there was no documentation in the rules and regulations, or medical staff by laws delineating such privileges for the PA-C. There was no documentation present in the PA-C privileging forms to assess their qualifications and competence to provide medical screening examinations in the emergency department and/or to determine if an emergency medical condition existed.	A 455	Corrective Action – Patients 62, 63, 64, 65, 66, 67, 68 • The Chief Medical Officer notified the ED Medical Director that physician assistants shall no longer perform medical screening examinations. (Attachment B) • The ED Medical Director informed each physician assistant, by e-mail, that they may no longer perform medical screen examinations. • The Interim Medical Director notified the head of the ED contractor that physician assistants could not be used to provide patient care at all in the ED (Attachment R) Permanent Actions: • The monitoring process described below will be used to monitor the effectiveness of the corrective actions Monitoring: • Ten randomly selected medical records will be reviewed daily to ensure that the medical screening exam is documented by an attending physician. Data will be presented to the Performance Improvement Committee and to the Executive Committee. Once the Executive Committee concludes that the process is stable, the daily record review will convert to a monthly review. Position Responsible: *ED Medical Director*	6/8/07

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A 455	Continued From page 60 Patients #5, #7, #9 and #15 had their medical screening examination in the main emergency room treatment area. The medical records showed the exams were performed by PA-Cs. There were no timed co-signatures of the records by a supervising physician. Review of the medical record for Patient #9 showed she presented to the ED at approximately 1400 hours, on 4/30/07, complaining of having a glass object "stuck" in her vagina. She complained of moderate aching pain. The nurse documented a PA-C saw the patient in triage at 1540 hours, but there was no documentation by the PA-C about the determination if an emergent medical condition existed. There was no treatment ordered or provided for the patient's pain. There was no documented re-assessment of Patient #9, until approximately 6 and 1/2 hours later, when a nurse saw her. A gynecological examination of the patient was ordered by the PA-C at approximately 2100 hours. The nurse documented an exam was done by a physician, but there was no documentation by a member of the medical staff of the patient's condition and or the treatment received. The patient was discharged at 2230 hours. The discharge instructions were written by the PA-C.	A 455	Background: • A further review of the chart disclosed that both an ED physician exam and a consultation with a GYN were documented; however, they were misfiled in the wrong section of the chart. Immediate Action: • A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triage policy was revised so that the triage registered nurse notifies medical provider if the patient is experiencing pain ≥ than 7/10 and follows physicians order to initiate pain medication for pain relief regardless of triage acuity level. The ED Nurse Manager provided in-service on the revised triage policy #114. • The ED Nurse Manager provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain, which requires interventions based on the pain policy. Permanent Action: • The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager will address deficiencies with responsible personnel. Monitoring: • The ED Nurse Manager or designee will review ten randomly selected charts each week to assess ED patients for appropriateness of pain intervention based on pain score. Deficiencies will be addressed by the ED Nurse Manager. Data fro the weekly reviews will be presented to the ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary and report it to Quality Council and Executive Committee, and as appropriate to Governing Body. Once audits demonstrate consistency, monitoring will be limited to ten charts monthly.	
A 456	482.55(a)(3) POLICIES The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff. This STANDARD is not met as evidenced by: Based on a review of policies, procedures, medical staff by-laws, rules and regulations and staff interviews, the hospital failed to ensure only	A 456		

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A 456	482.55(a)(3) POLICIES The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff. This STANDARD is not met as evidenced by: Based on a review of policies, procedures, medical staff by-laws, rules and regulations and staff interviews, the hospital failed to ensure only	A 456	• The ED Nurse Manager provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain, which requires interventions based on the pain policy. Permanent Action • The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager, will address deficiencies with responsible personnel.	6/8/07 6/7/07

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A 456	482.55(a)(3) POLICIES The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff. This STANDARD is not met as evidenced by: Based on a review of policies, procedures, medical staff by-laws, rules and regulations and staff interviews, the hospital failed to ensure only	A 456		

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A 456	Continued From page 61 qualified staff provided medical screening examinations and medical specialty consultations in the emergency department (ED). In addition, the hospital failed to ensure the policies and procedures (P&P) for triage, pain management and/or care of psychiatric patients presenting to the ED were followed for 12 of 68 sampled patients. (Patient #2, #3, #5, #6, #7, #26, #28, #29, #36 #49, #50 and #69). Findings: 1. On 5/31/07, the ED triage P&P (#114) identified that a patient presenting to the ED with "severe pain in distress" should be assigned a triage category of "Level II." This category was defined as "Emergent...Major injury or illness, unstable." The P&P specified that a Level II patient should be considered "threatened", be treated or re-assessed within 10 minutes and have continuous monitoring. This P&P specifying immediate treatment and continuous monitoring was not implemented for Patients #2, #26, #50 and #69 when they presented to the ED with severe pain. Cross reference to A455. 2. On 5/31/07, the ED triage P&P (#114) stated that a patient who was triaged as a Urgent Level III, stable major illness or injury should receive treatment or re-assessment of their condition within two hours. This P&P was not followed for Patients ##5, #7 and #26, who were assessed as a triage Level III. Cross reference to A455. 3. The triage P&P stated that Tylenol could be given in the triage area. There was no evidence this treatment was initiated in the triage area for the pain and fever of Patient #69 or for the pain of Patients	A 456	Finding 1 Immediate Actions 1) The ED nurse manager designated a nurse educator to provide reinforced education of ED policy #114 to ensure that patient are appropriately triaged and assigned a triage acuity level based on the Emergency Severity Index. The Nurse Educator provided supplemental training on DATE. Permanent Actions: Use of the monitoring below will assure that the deficiency remains corrected. The ED Nurse Manager or designee will provide remedial training where a pattern of deficient practices is identified. Monitoring: The ED nurse manager or designee will review ten randomly selected charts each week to assess for appropriateness of triage acuity score based on the Emergency Severity Index and the existence of timely reassessment. Deficiencies will be addressed by the ED Nurse Manager. Data from the weekly reviews will be presented to ED Collaborative. ED Collaborative reports data and proposed corrective actions to QPIC and Department of Emergency Medicine monthly which will evaluate it, create corrective actions as necessary, and report it to the Quality Council and Executive Committee and as appropriate, the Governing Body. Person Responsible: Chief Nursing Officer	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 456	Continued From page 62 #2, #5, #7, #26 and #50. Cross reference to A455. 4. The hospital's medical staff by-laws, rules and regulations were reviewed on 5/30/07. They did not specify which types of practitioners could provide medical screening examinations in the general ED. There was no documentation delineating such privileges for a physician assistant (PA-C) except in the obstetrical areas. The EMTALA Compliance Policy and Procedure (P&P HA 316) stated "The categories of persons qualified to perform emergency medical examinations shall be limited to physicians (in PES and OB areas PA's and Nurse Midwife's perform MSE on patients, but a physician must review and co-sign the chart before the patient is discharged or admitted." Patients #62, #63, #64, #65, #66, #67, #68, were triaged on 5/30 and/or 5/31/07 and sent to Adult Urgent Care, an extension of the ED, for their medical screening examinations and treatment. Each patient had their medical screening examination and treatment done by a PA-C. The patients' medical records revealed they were evaluated, treated and discharged from Adult Urgent Care, prior to the time of supervision or monitoring by the ED physician. When interviewed on 5/31/07 at approximately 1030 hours, the PA-C stated medical screening examinations, in the Adult Urgent Care, were provided by the PA-C. The physician made rounds every two hours to sign the patient's medical record. Patients #5, #7, #9 and #15 had their medical screening examination in the main emergency	A 456	Finding 4 • The Interim Chief Medical Officer notified the ED Medical Director that physician assistants shall no longer perform medical screening examinations (Attachment). The ED Medical Director informed each physician assistant by email that they may no longer perform individual medical screening examinations. • Interim Chief Medical Officer notified the head of the contract physician group that PA's may not provide treatment in the ED (Attachment R **Permanent Actions:** The monitoring described below will be used to assure that the effectiveness of the corrective actions is maintained. The Chief Medical Officer will address deficiencies with the Medical Director of the ED and require immediate remediation. **Monitoring:** • Quality Improvement will review ten randomly selected charts weekly to assess documentation that medical screening examination was performed by a physician. Deficiencies will be reported to the ED Collaborative Committee and the Quality Council and Executive Committee, and when appropriate the Governing Body. Once audits demonstrate consistency, monitoring will be limited to charts monthly. **Responsible Person:** QI Director	

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A 456	Continued From page 63 room treatment area. The medical records showed the exams were performed by PA-Cs. There were no timed co-signatures of the records by a supervising physician. The credentials files for the PA-Cs failed to contain documentation in the privileging forms to assess their qualifications and competence to provide medical screening examinations in the emergency department and/or to determine if an emergency medical condition existed. 5. On 5/31/07, the hospital's EMTALA Compliance Policy and Procedure (HA 316) defined an emergency medical condition as one manifesting itself by acute symptoms of such severity in which the absence of immediate medical attention could be expected to place the health of the individual in serious jeopardy. The P&P identified emergency medical conditions included severe pain, psychiatric disturbances and and/or symptoms of substance abuse. It specified that a medical screening examination was a continuous process reflecting ongoing monitoring until the individual was stabilized or appropriately transferred. It defined stabilization of the patient as the With respect to psychiatric patients it was defined as either the time when they no longer posed a danger to themselves or others or when it had been determined there was no underlying organic cause for the mental disturbance. The hospital failed to ensure implementation of this policy and procedure for 20 of 68 sampled patients. Cross reference to A 455. 6. Number 105 of the medical staff rules and regulations stated " Any patient evaluated in the	A 456	Finding 5 **Permanent Action:** On 5/17/07 and continuing to 5/20/07, the ED nurse manager provided all ED staff a copy of hospital policy #316 entitled "EMTALA Compliance" and received signed acknowledgement of receipt form all ED staff. The Nursing Manager provided all ED staff who are not *on active leave with training on the requirements of* EMTALA. • Employees who have not completed this policy training due to long term leave will be provided a copy of these policies and receive EMTALA education upon their return to work. • The charge nurse on each shift will be responsible for reviewing the people in the ED waiting room at least once per shift to determine whether they are patients waiting for service. Anyone without an identification band will be questioned as to their status and appropriately directed. The nursing shift supervisor will randomly verify that individual Patients in the ED waiting area have been registered and are either waiting for triage or are waiting for medical screening examination and where appropriate, having the patient seen. Person Responsible: Chief Nursing Officer	

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A 456	Continued From page 64 emergency room ... who is known or suspected to be suicidal, otherwise self injurious, or has taken a chemical overdose shall have psychiatric consultation." Number 69 of the medical staff rules and regulations stated that patients were to be seen within one hour for emergency consultations. The hospital failed to ensure implementation of the rules and regulations by allowing the PA-C to respond for the medical specialty physician on call for Patients #2, #36 and #50, for not ensuring timely response to the consultation request for Patient #2 and failing to ensure psychiatric patients (#3, #28 and #29 and #49) received consultation by a psychiatrist. When interviewed on 06/01/07, the medical director stated that psychiatric physician staff were immediately available in the hospital. Cross refer to A 455. 7. The pain management P&P (HA 377) specified that "All clinical departments shall implement procedures for early recognition of pain and prompt effective treatment..." Prompt effective treatment was not rendered for the pain experienced by Patients #2, #5, #6, #7, #26, #50 and #69 while they were in the ED. Cross reference to A455. 8. The medical staff by-laws stated membership in the medical staff association was limited to physicians, podiatrist, dentists and clinical psychologists. The by-laws stated an association members duties included "Participation in such emergency coverage...as may be determined by the association." The hospital failed to ensure the neurosurgery and general surgery physicians, on call for the ED, responded when called for emergency consultation for Patients #2, #36 and	A 456	Finding 6 **Immediate Action:** • In addition, in cases where physician consultants are required to assess a patient for an emergency medical condition, the Interim Chief Medical Officer ordered all MLK Department Chiefs to discontinue the practice of using Physician Assistants for consultations in the ED. All ED consultations will be performed by an attending physician (Attachment BB) • The ED nurse manager provided a letter instructing all ED RNs regarding physician assistants cannot provide consults (Attachment JJ) • The Interim Medical Director instructed all Department Chairs to ensure that their physicians provide timely consultation for patients in the Emergency Department.(X) **Permanent Action:** Use of the monitoring discussed below will assure that the deficiencies remains permanently corrected. **Monitoring:** For the next 30 days, Monday through Friday, Quality Improvement staff will review ten randomly selected open medical records in the ED to validate consult are performed by a physician and that there is a consulting physician's note. The Chair of the relevant Department will be notified of discrepancies for immediate corrective action. Responsible Person: Chief Medical Officer See Tag A186 for additional detail.	

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A 456	Continued From page 64 emergency room ... who is known or suspected to be suicidal, otherwise self injurious, or has taken a chemical overdose shall have psychiatric consultation." Number 69 of the medical staff rules and regulations stated that patients were to be seen within one hour for emergency consultations. The hospital failed to ensure implementation of the rules and regulations by allowing the PA-C to respond for the medical specialty physician on call for Patients #2, #36 and #50, for not ensuring timely response to the consultation request for Patient #2 and failing to ensure psychiatric patients (#3, #28 and #29 and #49) received consultation by a psychiatrist. When interviewed on 06/01/07, the medical director stated that psychiatric physician staff were immediately available in the hospital. Cross refer to A 455. 7. The pain management P&P (HA 377) specified that "All clinical departments shall implement procedures for early recognition of pain and prompt effective treatment..." Prompt effective treatment was not rendered for the pain experienced by Patients #2, #5, #6, #7, #26, #50 and #69 while they were in the ED. Cross reference to A455. 8. The medical staff by-laws stated membership in the medical staff association was limited to physicians, podiatrist, dentists and clinical psychologists. The by-laws stated an association members duties included "Participation in such emergency coverage...as may be determined by the association." The hospital failed to ensure the neurosurgery and general surgery physicians, on call for the ED, responded when called for emergency consultation for Patients #2, #36 and	A 456	Background: • The hospital believes that a neurosurgery consult was necessary as subsequent tests showed that the shunt had not malfunctioned. • The ED Nurse Manager provided a letter instructing all ED RNs regarding Physician Assistants cannot provide consults (Attachment J) The Interim Chief medical Officer ordered all MLK Department Chiefs to discontinue the practice of using Physician Assistants for consultations in the Ed. All ED consults will performed by an attending physician (Attachment BB	

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A 456	Continued From page 65 #50. Cross reference to A455. 9. The P&P #118 for Management of Psychiatric Patients, identified that if a patient met the criteria of being a danger to himself, danger to others, or was gravely disabled they would be brought back to the treatment area of the ED immediately. The physician was to be immediately notified for a psychiatric consult request. This P&P for taking the patient directly back to the treatment area and/or psychiatric consultation was not implemented for Patients #3, #28, #29 and #49 when they presented to the ED meeting one or more of these criteria. Cross reference to A455. 10. Hospital P&P for MAC transfer process (#HA 392) stated that if a Urgent/Emergent patient was not transferred to another hospital for the appropriate level of care within 48 hours, the case would be referred to the MAC medical director to expedite the transfer. Patient #50 required a higher level of care when he presented to the ED on 2/28/07. Four days later he had not been transferred. There was no documented evidence the MAC medical director was contacted to expedite the patient's transfer. Cross reference to A455.	A 456	Finding 8 cont'd • The interim Chief medical Officer instructed all Department Chiefs to ensure that all attending physicians are aware of the need to document their consultations (Attachment 5 • The Interim Medical Director notified all department chiefs that all Emergency Department consults must be completed within one hour of request. **Permanent Action:** The monitoring process described below will e used to assure the continuing effectiveness of these corrective actions. The chair of the relevant consulting department will address with responsible personnel deficiencies. **Monitoring:** For the next 30 days, Monday through Friday, Utilization Review nurses will review ten randomly selected open medical records in the ED to validate that consults were performed by a physician's note and that the consultation was timely. The Chair of the relevant department will be notified of discrepancies for immediate corrective action. Each month for the next six months the medical records of a minimum of ten patients, or, if fewer, 100% of pediatric patients presenting to the Pediatric Urgent Care with a neurosurgery diagnosis will be reviewed by the Chairman of Pediatrics for compliance. Deficiencies will be addressed by the Chairman of Pediatrics and referred to the Medicine Performance Improvement Committee as appropriate, and to the Physician Performance Improvement Committee for corrective actions, if necessary. As appropriate actions will be reported to the Executive Committee and Governing Body. **Responsible Person:** ED Medical Director, Interim Chief Medical Officer	
A 459	482.55(b)(2) QUALIFIED PERSONNEL There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility. This STANDARD is not met as evidenced by: Based on medical record, credential file and hospital document review, observation and staff interview, the hospital failed to ensure adequate	A 459		

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A 459	482.55(b)(2) QUALIFIED PERSONNEL There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility. This STANDARD is not met as evidenced by: Based on medical record, credential file and hospital document review, observation and staff interview, the hospital failed to ensure adequate	A 459	Body. Once audits demonstrate consistency, monitoring will be limited to ten charts monthly.	

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A 459	482.55(b)(2) QUALIFIED PERSONNEL There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility. This STANDARD is not met as evidenced by: Based on medical record, credential file and hospital document review, observation and staff interview, the hospital failed to ensure adequate	A 459		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 459	Continued From page 66 numbers of qualified nursing and medical staff to ensure timely and appropriate evaluation of the emergency medical conditions of 19 of 68 patients, when they presented to the emergency department (Patients#2, #3, #5, #7, #9, #15, #26, #28, #29, #49 #50, #62, #63, #64, #65, #66, #67, #68 and #69). Findings: 1. Medical staff interviews on 5/31/07 revealed PA-C s were conducting medical screening examinations(MSEs) in the adult urgent care area of the ED. There was no documented evidence in the credential files for these individuals, that they had demonstrated competence and had been granted privileges to conduct these examinations. The medical records for Patients #5, #7, #9, #15, #62, #63, #64, #65, #66, #67 and #68, showed their MSEs had been conducted by PA-Cs. 2. a. Review of medical records revealed long delays in receiving medical care for patients after they were taken to the treatment area of the ED. The medical record showed Patient #69 presented to the ED with severe abdominal pain and a fever. She was taken to the treatment area at 0110 hours on 3/8/07, but did not receive a medical screening examination until five hours later. 2.b. The medical record for Patient #3 showed the suicidal patient was taken to the treatment area of the ED at 2200 hours on 4/30/07. He did not receive a medical screening examination until seven hours later. 2.c. The medical record for Patient #62 showed she was complaining of severe pain from a dog	A 459	Finding 1B cont'd • The respective facility Patient Flow Managers shall work with MAC to coordinate the transfer via ACLS transport. • All appropriate and completed documents and imaging studies shall accompany the patient. • If the ED physician determines that there is ANY impediment to the transfer, he/she shal contact the Chief Medical Officer at the receiving facility to facilitate the transfer. • MLK-H has identified a medical administrative director in charge of patient flow. This Patient Flow Manager notifies the medial administrative director whenever there are impediments to transferring a patient, including a neurosurgical patient, in a timely manner. The medial administrative director will assure that there is high level physician contact with potential receive institutions in an effort to expedite transfer.	

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A 459	Continued From page 67 bite when she presented to the ED, at 1612 hours on 5/31/07. The nurse documented that she was also bleeding from the bite. She was taken to the treatment area of the ED at 1820 hours, but there was no documented medical screening examination of Patient #62 for approximately five more hours, to determine if she had an emergency medical condition. 2.d. The medical record for Patient #29 indicated she came in with the paramedics to the treatment area of the ED on 4/28/07 after taking an overdose. There was a one hour delay before a medical screening examination was conducted. 2.e. Cross refer to A455 for failure of the medical staff to provide continuing evaluation of the medical condition of Patient #50 during his three day stay in the ED. 3.a. On 5/31/07 review of the hospital's triage P&P, stated that a patient with severe pain should be treated or re-assessed within 10 minutes of being seen by the nurse for triage. It further stated that the patient should have continuous monitoring. The medical record showed Patient #26 was not re-assessed or treated for approximately 5 hours after he presented to the ED with severe abdominal pain. 3. b. The medical record for Patient #5 documented he did not receive a triage assessment by the nursing staff for three hours. He did not receive medical treatment for approximately 10 hours after presenting to the ED with severe flank pain. 3. c. The medical record for Patient #7 showed she presented to the ED with severe abdominal	A 459	Immediate Actions • The ED Medical Director provided education for all ED physicians on "change of shift and *patient hand-off recommendations.*" This directive requires specific acknowledgement and documentation of the hand-offs on each shift (Attachment K). • A hospitalist position on all shifts was added to the Emergency Department team to assume responsibility for the care of internal medicine patients who are admitted to MLK-H and are awaiting a bed placement. If there are not beds available at MLK-H, the hospitalist assumes responsibility for *facilitating the transfer. While the patient is* awaiting transfer or admission, the hospitalist is responsible for writing holding orders, reassessing the patient periodically, and modifying the plan of care as required. However, the ED physician remains responsible for neurosurgical, orthopedic and psychiatric patients awaiting transfer and other departments would assume responsibility for their patients. • For the ED physicians, the smart chart (a physician documentation record, which is a tool, used to assure consideration of important clinical questions) was implemented to improve physician documentation and to capture encounter times.	6/9/07 3/07

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A 459	Continued From page 67 bite when she presented to the ED, at 1612 hours on 5/31/07. The nurse documented that she was also bleeding from the bite. She was taken to the treatment area of the ED at 1820 hours, but there was no documented medical screening examination of Patient #62 for approximately five more hours, to determine if she had an emergency medical condition. 2.d. The medical record for Patient #29 indicated she came in with the paramedics to the treatment area of the ED on 4/28/07 after taking an overdose. There was a one hour delay before a medical screening examination was conducted. 2.e. Cross refer to A455 for failure of the medical staff to provide continuing evaluation of the medical condition of Patient #50 during his three *day stay in the ED.* 3.a. On 5/31/07 review of the hospital's triage P&P, stated that a patient with severe pain should be treated or re-assessed within 10 minutes of being seen by the nurse for triage. It further stated that the patient should have continuous monitoring. The medical record showed Patient #26 was not re-assessed or treated for approximately 5 hours after he presented to the ED with severe abdominal pain. 3. b. The medical record for Patient #5 documented he did not receive a triage assessment by the nursing staff for three hours. He did not receive medical treatment for approximately 10 hours after presenting to the ED with severe flank pain. 3. c. The medical record for Patient #7 showed she presented to the ED with severe abdominal	A 459	**Immediate Actions** • The ED Medical Director provided education for all ED physicians on "change of shift and patient hand-off recommendations." This directive requires specific acknowledgement and documentation of the hand-offs on each shift (Attachment K). • A hospitalist position on all shifts was added to the Emergency Department team to assume responsibility for the care of internal medicine patients who are admitted to MLK-H and are awaiting a bed placement. If there are not beds available at MLK-H, the hospitalist assumes responsibility for facilitating the transfer. While the patient is awaiting transfer or admission, the hospitalist is responsible for writing holding *orders, reassessing the patient periodically,* and modifying the plan of care as required. However, the ED physician remains responsible for neurosurgical, orthopedic and psychiatric patients awaiting transfer and other departments would assume responsibility for their patients. • For the ED physicians, the smart chart (a physician documentation record, which is a tool, used to assure consideration of important clinical questions) was implemented to improve physician documentation and to capture encounter times	6/9/07 3/07

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A 459	Continued From page 67 bite when she presented to the ED, at 1612 hours on 5/31/07. The nurse documented that she was also bleeding from the bite. She was taken to the treatment area of the ED at 1820 hours, but there was no documented medical screening examination of Patient #62 for approximately five more hours, to determine if she had an emergency medical condition. 2.d. The medical record for Patient #29 indicated she came in with the paramedics to the treatment area of the ED on 4/28/07 after taking an overdose. There was a one hour delay before a medical screening examination was conducted. 2.e. Cross refer to A455 for failure of the medical staff to provide continuing evaluation of the medical condition of Patient #50 during his three day stay in the ED. 3.a. On 5/31/07 review of the hospital's triage P&P, stated that a patient with severe pain should be treated or re-assessed within 10 minutes of being seen by the nurse for triage. It further stated that the patient should have continuous monitoring. The medical record showed Patient #26 was not re-assessed or treated for approximately 5 hours after he presented to the ED with severe abdominal pain. 3. b. The medical record for Patient #5 documented he did not receive a triage assessment by the nursing staff for three hours. He did not receive medical treatment for approximately 10 hours after presenting to the ED with severe flank pain. 3. c. The medical record for Patient #7 showed she presented to the ED with severe abdominal	A 459	• The ED Medical Director informed ED physicians at a department meeting, and follow-up with a written directive to all ED physicians, that they were responsible for assessing all active patients and patients waiting for transfer at the beginning of each shift. They were also informed of their responsibility to meet with oncoming physicians at the end of shift to provide appropriate information as part of the pass on process. Physicians were also reminded to document the patient's condition at change of shift and to document that the patient's care was transferred to the oncoming physician by name. • An outside consultant, provided reinforcing education to all ED nursing leadership on the importance of patient advocacy, particularly as it relates to chain of command and nurse-to-physician communication. **Monitoring:** • Ten charts will be randomly reviewed each week to validate the documentation of physician involvement at the change of shift and hospitalist involvement with patients awaiting admission or transfer. Deficiencies will be addressed with the department chair. Results of these audits will be provided to the Performance Improvement Committee, which will review and create corrective action as necessary. This data will then be reported to Executive Committee and to the Governing Body as appropriate. **Position Responsible:** Chair, Department of Internal Medicine ED Medical Director	6/5/07

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A 459	Continued From page 67 bite when she presented to the ED, at 1612 hours on 5/31/07. The nurse documented that she was also bleeding from the bite. She was taken to the treatment area of the ED at 1820 hours, but there was no documented medical screening examination of Patient #62 for approximately five more hours, to determine if she had an emergency medical condition. 2.d. The medical record for Patient #29 indicated she came in with the paramedics to the treatment area of the ED on 4/28/07 after taking an overdose. There was a one hour delay before a medical screening examination was conducted. 2.e. Cross refer to A455 for failure of the medical staff to provide continuing evaluation of the medical condition of Patient #50 during his three day stay in the ED. 3.a. On 5/31/07 review of the hospital's triage P&P, stated that a patient with severe pain should be treated or re-assessed within 10 minutes of being seen by the nurse for triage. It further stated that the patient should have continuous monitoring. The medical record showed Patient #26 was not re-assessed or treated for approximately 5 hours after he presented to the ED with severe abdominal pain. 3. b. The medical record for Patient #5 documented he did not receive a triage assessment by the nursing staff for three hours. He did not receive medical treatment for approximately 10 hours after presenting to the ED with severe flank pain. 3. c. The medical record for Patient #7 showed she presented to the ED with severe abdominal	A 459	**Immediate Actions:** The ED Nurse Manager designated a nurse educator to provide reinforced education of ED policy #114 to ensure that patients are appropriately triaged and assigned a triage acuity level based on the Emergency Severity Index. The nurse educator proved this supplemental training. This policy covers the need to reassess patients within certain time frames while the patient is waiting for an medical screening examination (Attachment O). **Permanent Actions:** The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager will address deficiencies with responsible personnel. **Monitoring:** The ED Nurse Manager or designee will review ten randomly selected charts each week to assess for appropriateness of triage acuity score based on the Emergency Severity Index. The ED Nurse Manager will address deficiencies with responsible individuals. Data from the weekly reviews will be presented to ED Collaborative Practice Committee. Data will also be presented to the QPIC Council monthly, which will evaluate it, create corrective actions as necessary, and report it to the Quality Council and Executive Committee and as appropriate, the Governing Body. Once audits demonstrate consistency, monitoring will be limited to 10 charts monthly. **Responsible Positions:** Chief Nursing Officer ED Nurse Manager 1) A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triage policy was revised so that the triage registered nurse notifies the medical	6/5/07 – 6/14/07, 6/18/07 6/21/07 6/5/07 – 6/14/07, 6/19/07

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A 459	Continued From page 67 bite when she presented to the ED, at 1612 hours on 5/31/07. The nurse documented that she was also bleeding from the bite. She was taken to the treatment area of the ED at 1820 hours, but there was no documented medical screening examination of Patient #62 for approximately five more hours, to determine if she had an emergency medical condition. 2.d. The medical record for Patient #29 indicated she came in with the paramedics to the treatment area of the ED on 4/28/07 after taking an overdose. There was a one hour delay before a medical screening examination was conducted. 2.e. Cross refer to A455 for failure of the medical staff to provide continuing evaluation of the medical condition of Patient #50 during his three day stay in the ED. 3.a. On 5/31/07 review of the hospital's triage P&P, stated that a patient with severe pain should be treated or re-assessed within 10 minutes of being seen by the nurse for triage. It further stated that the patient should have continuous monitoring. The medical record showed Patient #26 was not re-assessed or treated for approximately 5 hours after he presented to the ED with severe abdominal pain. 3. b. The medical record for Patient #5 documented he did not receive a triage assessment by the nursing staff for three hours. He did not receive medical treatment for approximately 10 hours after presenting to the ED with severe flank pain. 3. c. The medical record for Patient #7 showed she presented to the ED with severe abdominal	A 459	2) The ED Nurse Manager provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain, which requires interventions based on the pain policy (Attachment IV) **Permanent Actions:** • The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager will address deficiencies with responsible personnel. **Monitoring:** • The ED Nurse Manager or designee will review ten randomly selected charts each week to assess ED patients for appropriateness of pain intervention based on pain score. Deficiencies will be addressed by the ED Nurse Manager. Data from the weekly reviews will be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary, and *report it to the Quality Council and Executive* Committee and as appropriate to Governing Body. Once audits demonstrate consistency, monitoring will be limited to 10 charts monthly. • The charge nurse on each shift will be responsible for reviewing the people in the ED waiting room at least once per shift to determine whether they are patients waiting for service. Anyone without an identification band will be questioned as to their status and appropriately directed. • The nursing shift supervisor will randomly verify that individual patients are entered into the central log. Any patient not entered into the ED central log shall be immediately entered into the central log. Reports of any variances will be recorded in the Daily Nursing Report.	

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A 459	Continued From page 68 cramping during her pregnancy. She also complained of vaginal bleeding. She was not re-evaluated by the nursing staff and did not receive a medical examination for approximately four hours. 3. d. The medical record showed Patient #69 presented to the ED with severe abdominal pain and a fever. She did not receive a re-assessment of her condition by the nursing staff for two hours. 3. e. The medical record for Patient #50 showed he presented to the ED with complaint of a severe headache on 2/28/07. There was no documented re-assessment of his condition by the nursing staff for three hours. 3 .f. The medical record for Patient #2 documented she came to the ED complaining of severe sharp pain in her abdomen. There was no documented nursing re-assessment of her condition for approximately 5 hours. 3. g. The medical record for Patient #62 showed she was complaining of severe pain from a dog bite when she was triaged by the nurse 1820 hours on 5/31/07. There was no documented re-assessment of the patient's condition for approximately 5 hours. 4. a. Hospital P&P #118 for care of psychiatric patients stated someone presenting as a danger to themselves would be taken to the treatment area immediately. The medical record for Patient #3 indicated he presented to the ED with suicidal ideation and a plan to drink bleach. Documentation shows he was left to sit in the lobby without a nursing re-assessment for	A 459	**Immediate Actions:** Effective May 29, 2007, the policy entitled Management of Psychiatric Patients #118 for the Emergency Department was revised to address the needs of psychiatric patients presenting to the MLK-H emergency department. The ED Nurse Manager completed in-service on the revised policy with emphasis that at no time should the patient be left alone. (Attachment W) **Permanent Action:** The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager will address identified deficiencies with responsible personnel. **Monitoring:** The ED Nurse Manager or designee will review ten randomly selected charts each week to assess for appropriateness of triage acuity score based on the Emergency Severity Index. The ED Nurse Manager will address deficiencies with responsible individuals. Data from the weekly reviews will be presented to ED Collaborative Practice Committee. Data will also be presented to the QPIC Council monthly, which will evaluate it, create corrective actins as necessary, and report it to the Quality Council and Executive Committee and as appropriate, the Governing Body. Once audits demonstrate consistency, monitoring will be limited to ten charts monthly. **Responsible Positions:** Chief Nursing Officer ED Medical Director ED Nurse Manager	5/29/07

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A 459	Continued From page 69 approximately one hour. 4. b. The medical record for Patient #28 showed he was assessed by the triage nurse at 2106 hours on 4/28/07 as having thoughts of wanting to hurt himself. The nurse documented he had tried to commit suicide in the past. There was no documented re-assessment of his condition by the nursing staff for three hours. He was not taken to the treatment area for three hours after he was triaged. 4. c. Patient #49 presented to the ED at 0302 hours with a chief complaint of violent behavior, not taking his medications and was experiencing auditory hallucinations. At 0535 hours, nursing documented that the patient had left without being seen.	A 459		

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A 000	INITIAL COMMENTS The following represents the findings of the Department of Health Services during a survey for EMTALA complaint # 117102 conducted concurrently with a complaint survey. Representing the Department were Jo Ann Dalby, RN, HFES; Barbara Mellor, RN, HFEN; and Sanford Weinstein, MD, Medical Consultant. The original document prepared for the investigation, # M80Z11, identified a patient sample size of 60. Eight additional patients were reviewed for this document for a total sample size of 68. The original document cited Patients A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q. These patients are cited in this document using the following identifiers respectively: Patient #50, #69, #36, #26, #5, #6, #7, #66, #67, #68, #62, #63, #64, #65, #2, #23, #3. Additional Patients affected by the hospital's non-compliance with EMTALA requirements cited in this document are Patients #9, #15, and #29.	A 000		
A 400	489.20(l) COMPLIANCE WITH §489.24 The provider agrees, in the case of a hospital as defined in §489.24(b), to comply with §489.24. This STANDARD is not met as evidenced by: Based on review of medical record reviews, policies and procedures (P&Ps), medical staff by-laws, rules and regulations, and staff interviews, the hospital failed to comply with the requirements of 42 CFR 489.24. Findings: 1. The hospital failed to ensure 11 of 68 sampled	A 400		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/10/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 400	Continued From page 1 patients received appropriate medical screening examinations within the capacity of the hospital's emergency department. In addition, the hospital failed to ensure that medical screening examinations for 11 of 68 sampled patients were provided by qualified medical personnel. Please refer to A 406. 2. The hospital failed to provide stabilizing treatment of an emergent medical condition for 10 of 68 sampled patients. Please refer to A 407. 3. The hospital failed to provide appropriate transfers to a higher level of care for two of 68 sampled patients. Please refer to A 407.	A 400	Steps have been taken to assure that all patients presenting to the ED will receive a medical screening examine by a physician. Please refer to tag A 406 for a more detailed response. The medical staff has taken steps to assure that all patients are seen by a physician in timely manner, have access to appropriate and timely ancillary services, and receive stabilizing treatment within the capacity of the hospital. Please refer to A 407 for a more detailed response.	
A 405	489.20(r)(3) ER LOG The provider agrees, in the case of a hospital as defined in §489.24(b) (including both the transferring and receiving hospitals), to maintain a central log on each individual who comes to the emergency department, as defined in §489.24(b), seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged. The provisions of this regulation apply to all hospitals that participate in Medicare and provide emergency services. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure there was a central log accurately identifying when patients came to the emergency room seeking assistance and their	A 405	Medical staff has revised the transfer process for patients. Please refer to A407 for a more detailed response.	

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A 405	Continued From page 2 disposition on discharge. Findings: 1. The ED log showed Patient #5 came to the emergency department (ED) at 1510 hours on 5/11/07. The medical record revealed that Patient #5 had actually been assessed by the triage nurse three hours earlier, at 1139 hours on 5/11/07. 2. The medical record identified Patient #14 came to the ED on 1/26/07 and was seen in triage at 1224 hours. The time of entry in the ED log read "1324 hours". 3. The medical record for Patient #6 showed he presented to the ED for triage at 1812 hours on 5/11/07 and left without being seen for a medical screening exam. He was not logged into the ED log until 1913 hours and the log failed to identify that he left without being seen. 4. The medical record for Patient #16 showed he was triaged in the ED at 1340 hours on 12/3/06 and was transferred to another hospital at 0730 hours on 12/4/06. The ED log stated he presented to the ED at 1402 hours on 12/3/06 and was transferred at 0950 hours on 12/4/06. 5. At 0900 hours on 5/30/07 the ED log was requested. When received on 5/31/07, the log failed to contain information for patients seen in the pediatric and adult urgent care areas of the hospital after they were triaged in the ED. The information technology representative revealed that the "emergency department log" contained only those patients evaluated in the main emergency room. Separate patient logs existed	A 405	Finding 1,2, 4 Immediate actions: 1) Facility investigation determined that when patients presented to the ED, the registered nurse evaluated the patient initially and completed the flow sheet. After this evaluation, the patient was seen by registration. The electronic ED log defaulted to the time of entry by the registration staff. That led to the discrepancies noted by the survey. A multidisciplinary group reviewed and revised emergency registration/admitting policy #1.1.32 entitled Registration and Financial Screening to require original time of arrival be entered into the computerized central log to be congruent with the nursing flow sheet. The screen was modified to require the clerk in registration to validate the date and time entered is the same as the nursing flow sheet. Permanent Action: Use of the monitoring discussed below will assure that the deficiency remains permanently corrected until implementation of ATEMM system has been completed.	6/13/07

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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A 405	Continued From page 3 for ED patients seen in the Adult Urgent Care area and a separate log existed for the Pediatric Outpatient department. It was revealed that a complete log for all patients was known as the "EMTALA" log and this log contained all adult, pediatric and urgent care patients. When produced, the EMTALA log was not in chronological date/time order of when the patients presented to the ED.	A 405	Responsible Person: HIM Director Note: The ED Collaborative Committee is a multidisciplinary group that reviews patient care, patient flow and operations issues brought forth by a service. The forum is also used to discuss quality improvement monitoring findings and to develop plans for action to address issues identified. 405 #5 Immediate Actions: 1) Nursing administration re-trained all ED staff on the distinction between central log and working logs and their use. 2) Information Technology re-programmed the central log to default to display or print regardless of triage location. Permanent Action: Use of monitoring below will assure that the deficiency remains corrected. The HIM director will provide remedial training where a pattern of deficient practices is determined. Monitoring • PFS personnel will review the central EMTALA log monthly to verify that all patients regardless of treatment location (emergency department, adult urgent care, or pediatric urgent care) will appear in chronological date/time order of when the patient presented in the ED. Deficiencies will be reported to the HIM Director for corrective action. The need for further corrective action will be reported to the QPIC as appropriate. Responsible Position: HIM Director	
A 406	489.24(a) and 489.24(c) MEDICAL SCREENING EXAM In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction. If an emergency medical condition is determined to exist, the hospital must provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.	A 406		

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A 406	Continued From page 4 Sanctions under this section for inappropriate transfer during a national emergency do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of the Act. If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition. This STANDARD is not met as evidenced by: Based on medical record review, policy and procedure reviews, review of hospital documentation and staff interviews, the hospital failed to ensure medical screening examinations were provided by qualified individuals for 11 of 68 sampled patients presenting to the Emergency Department (ED) (Patients #5, #7, #9, #15, #62, #63, #64, #65, #66, #67, #68). In addition, the hospital failed to provide prompt medical screening examinations for 11 of 68 sampled patients (Patients #2, #3, #5, #6, #7, #9, #26, #29, #36, #50, #69). Findings: 1. Patient #50 presented to the ED (emergency department) on 2/28/07 at 0950 hours, with a chief complaint of headache (comes and goes) with occasional nausea. At the time of triage,	A 406	Finding 1 Immediate Actions: The ED nurse manager designated a nurse educator to provide reinforced education of ED policy #114 to ensure that patients are appropriately triaged and assigned a triage acuity level based on the Emergency Severity Index. The nurse educator provided this supplemental training (Attachment O). Permanent Actions: The monitoring process discussed below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager will address deficiencies with responsible personnel. Monitoring: The ED nurse manager or designee will review ten randomly selected charts each week to assess for appropriateness of triage acuity score based on the Emergency Severity Index, and, if applicable, whether the score was appropriately changed after the patient was reassessed. The ED Nurse Manager will address deficiencies with responsible individuals. Data from the weekly reviews will be presented to ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary, and report it to the Quality Council and Executive Committee and as appropriate, the Governing Body. Once audits demonstrate consistency, monitoring will be limited to 10 charts monthly. Immediate Actions: • The ED nurse manger provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain, which requires interventions based on the pain policy. (Attachment V,N) • A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of the that review, the triage policy was revised so that the triage registered nurse notifies the medical provider if the patient is experiencing pain ≥ 7/10 and follows physician's order to initiate pain medication for pain relief regardless of triage acuity level. The ED nurse manager provided in-service on the revised triage policy #114.	6/18/07 6/6/07 – 7/9/07 6/18/07

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A 406	Continued From page 5 1003 hours, the patient described that he was experiencing severe pain, that scored nine out of 10, on a scale of one to 10, with 10 being the most severe. The patient described that the pain was located at the back of his head and that it was relieved by vomiting. The patient was assigned a triage acuity of three. Per hospital policy, an acuity of three indicated the patient had a major illness or injury, but was stable. At 1250 hours, Patient #50 was taken to the treatment area. Nursing assessment at that time revealed " steady gait " , pupil sizes of 33 and 31 mm. A Glascow Coma Scale score of 15 was recorded (a standardized series of observations reflecting speech, pain, orientation and speech. A score of 15 is normal). Patient #50 was assessed by the emergency department physician, at which time "paraspinal tenderness" was noted, but no " Neuro" changes or " Psych" abnormalities recorded. A blood count revealed 16.4 gms. of hemoglobin and a white count of 10,800 (upper normal range). Morphine 4 mg was administered in the emergency department, however, the results of the medication administration was not recorded. A CT head scan was ordered by the ED physician. At 1550 hours Patient #50 was taken to CT. The report revealed, "significant ventricular dilatation with periventricular changes consistent with subependymal edema. This may be related to a heterogeneous mass near the region of the pineal with caudal extension to a level near the proximal fourth ventricle." The scan revealed a brain tumor measuring approximately 2.5 cm. compressing the internal circulation of fluid in the	A 406	Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED nurse manager, will address deficiencies with responsible personnel. Monitoring: • The ED nurse manager or designee will review ten randomly selected charts each week to assess ED Patients for appropriateness of pain intervention based on pain score. Deficiencies will be addressed by the ED Nurse Manager. Data from the weekly reviews will be presented to the ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary, and report it to the Quality Council and Executive Committee and as appropriate, the Governing Body. Immediate Actions: A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of the review, the triaging process was re-designed to provide for a more timely medical screening exam and treatment. This process includes the following: (Attachment O) o The triage nurse and registration clerk are co-located so that the triaging process and the registration process can occur simultaneously. o The physician will be available to the triaging area to perform immediate medical screening examinations for patients who are identified as a level 3. Upon completion of the medical screening examination, based on the patient's clinical presentation, tests and treatments (including pain management) will be ordered and carried out. o Patients who are identified as a Level 1 and 2 at the time of triage will be brought back to the emergency treatment area. At the time of arrival, the ED charge nurse will notify the physician of the patient's arrival by placing the patient's pseudo name on the white board along with the patient's priority number. The physician will acknowledge the patient by initialing the white board and will perform the medical screening examination as soon as possible. If the patient's condition is critical, the RN will verbally notify the physician of the patient's arrival.	6/18/07

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A 406	Continued From page 6 brain resulting in internal swelling from dilatation of the ventricular system of the brain. An MRI image of the brain was recommended and completed. This confirmed the presence of a tumor mass in the region of the pineal gland. Moderate dilatation of the ventricular system of the brain was noted. A handwritten note by the ED physician noted that Neurosurgery was not available at the hospital, "will arrange MAC transfer". (The MAC is the medical alert center for Los Angeles County. This is the central clearing house for all Los Angeles County hospitals.) However, there was no written documentation that physician to physician contact had been initiated. A clinical impression of "Acute Obstructive Hydrocephalus" was recorded. A physician order for a neurosurgery consult was written at 1653 hours on 2/28/07. A "Neurology Consultation" handwritten by a Physician Assistant (PA-C) identified that the patient was seen for evaluation at 1720 hours. The consultation revealed no neurological defects or alteration in mental status for Patient #50. The consult described symptoms of dizziness, nausea, headache and vomiting. The consultation, provided by the PA-C, was then countersigned by the attending neurology physician at 1900 hours. No written note was provided by the neurology physician. The medical record failed to contain documented evidence that the neurologist had actually examined Patient #50. This finding was in violation of the Medical Staff rules and regulations requiring a written note. The consultation request form revealed that "Stat MAC transfer to a facility with neurosurgical service" was required.	A 406	Monitoring: Starting July 1, 2007, Utilization Review staff will review at least 15% of patients weekly to track and trend data from arrival to triage and arrival to medical screening exam. Time of arrival to time of discharge is tracked electronically through the Affinity System for all patients and trended weekly. The information goes to the Emergency Department Collaborative Committee for evaluation. The report will go to both the ED Committee and the Quality/Performance Improvement Committee (QPIC), which will report this to the Executive Committee or Quality Council respectively, and then to the Governing Body. Position Responsible: ED Medical Director ED Nurse Manager (Additional issues for this patient are addressed under Tag 407)	

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A 406	Continued From page 7 A written order for "MAC transfer to Neurosurgical facility was provided at 1717 hours by the attending ED physician. There was, however, no written documentation that any physician had actually spoken with or discussed the emergent clinical situation of Patient #50 with a proposed receiving hospital to facilitate transfer for Patient #50. Documents contained in the medical record revealed that Patient #50 signed a transfer consent on 2/28/07. At 0350 hours on March 1, 2007, nursing notes revealed that Patient #50 was administered Dilaudid (narcotic pain medication) by IVP (intravenously push). There was no documented evidence that a ED physician had examined or assessed the neurological status of Patient #50. A nursing re-assessment performed at 0550 hours revealed that a neurocheck had been performed and the headache pain of Patient #50 had improved. Additional nursing assessments were performed at 0730, 0900,1100, 1300, 1500, and 1830 hours. These nursing assessments documented no change in the status of Patient #50 These assessments indicated that Patient #50 was able to move all four extremities and remained alert. No physician assessments were documented. Patient #50 remained in the ED until 3/3/07. Review of the medical record revealed that the patient was assessed by nursing staff and continued to received Dilaudid and morphine to control his headache pain. The nursing pain assessments included only a numerical score to identify the intensity of pain but failed to identify pain radiation, quality (ache, throbbing, sharp, dull, burning) and constancy as required by	A 406		

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A 406	Continued From page 8 established hospital policy. The medical record failed to provide documented evidence that ED physicians provided on-going assessments and care. Except for the initial consult, the neurologist did not see the patient again. On 3/3/07 at 0725 hours, nursing documentation identified that Patient #50 complained of occipital headache pain. Intensity of pain was recorded as 5/10. The patient was not given pain medication nor were non-medication interventions provided. Nursing documentation further identified that no deficits were noted. However, the very next sentence stated c/o (complaint of) blurred vision when ambulating. The patient was not evaluated for the neurological symptom by a physician. At 1100 hours, Patient #50 complained of increased head pain. The patient identified the intensity of pain as being 9/10 (severe). The patient received Dilaudid 1 mg. IV for pain. Although a physician order was obtained for the pain medication, the patient's medical record failed to contain documented evidence that the ED physician evaluated the patient. At 1150 hours, the patient and his family indicated that after three days, they were tired of waiting for transfer to another hospital. Patient #50 signed out AMA (against medical advise) to seek treatment elsewhere. The "Leaving Hospital against Medical Advice" form was noted to be incomplete. In addition, the medical record failed to contain documented evidence that at the time of discharge, the patient had been assessed by a physician or had received discharge instructions. On 6/1/07 and 6/5/07 discussions with hospital staff regarding the care of Patient #50 and quality	A 406		

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A 406	Continued From page 9 assurance, identified that the medical care received by Patient #50 was deemed to be appropriate. The hospital was requested to provide any and all documentation related to the patient's care as well as any quality of care reviews. A case review summary for Patient #50 was received at 1340 hours on 6/5/07. The case review confirmed a failure of the ED physicians to document assessments of Patient #50 for three days. Further review of the summary identified that there was a system wide plan to provide neurosurgical services and to streamline the transfer process of patients between hospitals. Patient #50 was a pending transfer to a higher level of care on 3/3/07 prior to leaving the hospital against medical advice. As of 6/7/07, the plan had not been implemented. 2. Patient #69 presented to the emergency department on 3/8/07 at 2242 hours, with a chief complaint of stomach pain for the past two weeks. The nurse documented that the pain was in all four quadrants and radiated in to the patient's back. It was documented that the patient had multiple episodes of nausea and vomiting today. The patient identified her pain as being severe with a score of 10 out of 10. The patient identified that the pain she was experiencing was constant and that nothing provided relief. The pain was further described as aching and burning with a pressure sensation. Nursing documentation revealed that the patient was moaning and had facial grimacing. Vital signs were recorded as Temperature 102.8 degrees, heart rate 97, respirations 24 and blood pressure was 133/59. No treatment was provided to alleviate pain or reduce the patient's fever at the	A 406	406-2 Pt. 69 **Immediate Actions:** The ED nurse manager designated a nurse educator to provide reinforced education of ED policy #114 to *ensure that patients are appropriately triaged and* assigned a triage acuity level based on the Emergency Severity Index. The nurse educator provided this supplemental training (Attachment O). **Permanent Actions:** Use of the monitoring discussed below will assure that the deficiency remains permanently corrected. **Monitoring:** • The ED nurse manager or designee will review ten randomly selected charts each week to assess for appropriateness of triage acuity score based on the *Emergency Severity Index. The ED Nurse* Manager will address deficiencies with responsible individuals. Data from the weekly reviews will be presented to ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary, and report it to the Quality Council and Executive Committee and as appropriate, the Governing Body. Once audits demonstrate consistency, monitoring will be limited to 10 charts monthly. **Positions Responsible:** *Chief Nursing Officer* ED Nurse Manager **mmediate Actions:** • A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of the that review, the triage policy was revised so that the triage registered nurse notifies the medical provider if the patient is experiencing pain ≥ 7/10 and follows physicians order to initiate pain medication for pain relief regardless of triage acuity level. The ED nurse manager provided in-service on the revised triage policy #114. • The ED *nurse manger* provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain, which requires interventions based on the pain policy (Attachment N,V)	6/18/07 6/18/07 6/6/07

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A 406	Continued From page 9 assurance, identified that the medical care received by Patient #50 was deemed to be appropriate. The hospital was requested to provide any and all documentation related to the patient's care as well as any quality of care reviews. A case review summary for Patient #50 was received at 1340 hours on 6/5/07. The case review confirmed a failure of the ED physicians to document assessments of Patient #50 for three days. Further review of the summary identified that there was a system wide plan to provide neurosurgical services and to streamline the transfer process of patients between hospitals. Patient #50 was a pending transfer to a higher level of care on 3/3/07 prior to leaving the hospital against medical advice. As of 6/7/07, the plan had not been implemented. 2. Patient #69 presented to the emergency department on 3/8/07 at 2242 hours, with a chief complaint of stomach pain for the past two weeks. The nurse documented that the pain was in all four quadrants and radiated in to the patient's back. It was documented that the patient had multiple episodes of nausea and vomiting today. The patient identified her pain as being severe with a score of 10 out of 10. The patient identified that the pain she was experiencing was constant and that nothing provided relief. The pain was further described as aching and burning with a pressure sensation. Nursing documentation revealed that the patient was moaning and had facial grimacing. Vital signs were recorded as Temperature 102.8 degrees, heart rate 97, respirations 24 and blood pressure was 133/59. No treatment was provided to alleviate pain or reduce the patient's fever at the	A 406	Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED nurse manager, will address deficiencies with responsible personnel. Monitoring: The ED nurse manager or designee will review ten randomly selected charts each week to assess ED Patients for appropriateness of pain intervention based on pain score. Deficiencies will be addressed by the ED Nurse Manager. Data from the weekly reviews will be presented to the ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary, and report it to the Quality Council and Executive Committee and as appropriate, the Governing Body. Once audits demonstrate consistency, monitoring will be limited to 10 charts monthly. • The charge nurse on each shift will be responsible for reviewing the people in the ED waiting room at least once per shift to determine whether they are patients waiting for service. Anyone without an identification band will be questioned as to their status and appropriately directed. • The nursing shift supervisor will randomly verify that individual patients are entered into the central log. Any patient not entered into the ED central log shall be immediately entered into the central log. Reports of any variances will be recorded in the Daily Nursing Report. Positions Responsible: Chief Nursing Officer ED Nurse Manager Immediate Actions: A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of the review, the triaging process was re-designed to provide for a timelier medical screening exam and treatment. This process includes the following:	

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A 406	Continued From page 10 time of triage. The patient was assigned a triage category of 3. Category or Level 3 patients are described as having a stable major injury or illness. Two hours later, at 0040 hours, Patient #69's vital signs were re-assessed. The patient had a temperature of 102.4 degrees, heart rate 102, respirations 20 and blood pressure was recorded as 118/62. The patient continued to experience severe abdominal pain. No treatments were provided in the triage area. At 0110 hours, the patient was transferred to the treatment area. The patient continued to have severe pain, recorded as 7/10. The patient received Tylenol 650 mg. and was placed on oxygen by mask. At 0220 hours, the patient was described to have decreased pain. At 0400 hours, nursing documentation revealed that the patient had no orders for care and was waiting for the physician assistant. This was approximately three hours after she was taken to the treatment area of the ED. Patient #69 was not evaluated by a physician until 0530 hours The patient was described as having a fever and was in moderate to severe distress. The patient continued to experience severe pain and nausea. The patient experienced severe pain throughout her ED stay. At 0950 hours, 11 hours after presenting to the ED, the patient was transferred to surgery services to undergo an exploratory laparotomy. 3. The medical record for Patient #26 documented the teenager presented to the emergency department (ED) at 2355 hours on	A 406	Immediate Actions: • The ED Nurse Manager designated a nurse educator to provide reinforced education of ED policy #114 to ensure that patients are appropriately triaged and assigned a triage acuity level based on the Emergency Severity Index. The nurse educator provided this supplemental training (Attachment O). Monitoring • A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of the that review, the triage policy was revised so that the triage registered nurse notifies medical provider if the patient is experiencing pain ≥ 7/10 and follows physicians order to initiate pain medication for pain relief regardless of triage acuity level.The ED nurse manager provided in-service on the revised triage policy #114. (Attachment P). • The ED nurse manger provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain, which requires interventions based on the pain policy (Attachment H). Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED nurse manager, will address deficiencies with responsible personnel. Monitoring: • The ED nurse manager or designee will review ten randomly selected charts each week to assess for appropriateness of triage acuity score based on the Emergency Severity Index, timely reassessment based on triage level and triage scores adjustment, if needed, and pain intervention based on pain score. The ED Nurse Manager will address deficiencies with responsible individuals. Data from the weekly reviews will be presented to the ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary, and report it to the Executive Committee and as appropriate, the Governing Body. Once audits demonstrate consistency, monitoring will be limited to 10 charts monthly.	6/18/07 6/18/07 6/18/07

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 406	Continued From page 11 2/12/07 with right abdominal pain. He was triaged by the nurse and determined to have pain of 10 on a 1-10 scale (10/10). His oxygen saturation level was 100%, his pulse 95 respirations were 18 and his blood pressure was 113/69. At 0040 hours the nurse documented the patient was complaining of difficulty breathing. The nurse documented he had wheezing in his lungs, his respiratory rate was 22 , blood pressure was 135/70, oxygen saturation was 97% and that he was anxious and restless. There was no documentation about why he was left in the lobby of the ED. No pain medication or other pain relieving interventions were provided. There was no re-assessment of the patient until he was taken to a treatment area five hours later. At 0530 hours on 2/13/07 his pain was 8/10. At 0645 hours laboratory tests and pain medication were ordered for Patient #26. The pain medication was administered at 0840 hours; approximately 8 and 1/2 hours after he presented to the ED. The laboratory test results were not available until 2100 hours. This was approximately 14 hours after they were ordered and 19 hours after Patient #26 came to the ED. There was no documented evidence the nursing or medical staff were following-up to ensure the laboratory test results were obtained. During interviews on 6/1/07 medical staff stated this patient "fell through the cracks." 4. a. The medical record for pediatric Patient #36 showed she presented to the emergency department at 1030 hours on 3/20/07 for vomiting, lethargy, cough and congestion. She had a history of a ventriculoperitoneal shunt for hydrocephalus and began to feel bad after a visit to the dentist. Documentation shows the presence of a shunt malformation and/or infection	A 406	Immediate Actions: • The Interim Chief Medical Officer notified all pediatric and pediatric urgent care physicians that they must follow the "Neurosurgical Patients at MLK-Harbor Hospital" transfer process for any pediatric patient presenting in the Pediatric Urgent Care with a potential neurosurgical emergency (Attachment I). — 7/3/07 • The Interim Chief Medical Officer ordered all MLK Department Chiefs to discontinue the practice of using Physicians Assistants for consultations in the ED. All ED consultations will be performed by an attending physician (Attachment X). — 6/18/07 • The ED Nurse Manager provided a letter instructing all ED RNs regarding Physicians Assistants cannot provide consults. (Attachment J) — 6/19/07 • The Interim Chief Medical Officer instructed all Department Chiefs to ensure that all attending physicians are aware of the need to document their consultations. (Attachment S) — 7/9/07 **The Interim Medical Director notified all department chiefs that all Emergency Department consults must be completed within one hour of request (Attachment S).** Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The chair of the relevant consulting department will address with responsible personnel deficiencies. Monitoring: Utilization Review nurses will review ten randomly selected open medical records in the ED to validate that consults were performed by a physician, that there is a consulting physician's note and that the consultation was timely. The Chair of the relevant department will be notified of discrepancies for immediate corrective action.	

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A 406	Continued From page 12 was being ruled out. A neurology consult was ordered. At 1230 the physician's assistant (PA) saw the patient to perform the neurology consultation. There was no documented evidence a neurologist saw the patient; however, the PA documented the recommended plan, in consultation with the neurologist, would be evaluation and management by a neurosurgeon on an urgent basis to assess the functioning of the shunt. Since neurosurgeons were not available at the hospital the PA recommended transfer to another hospital. The child was in the emergency department until 2200 hours but there was no documented evidence a neurosurgeon was contacted or that efforts were made to transfer the patient to a hospital with this service available. The patient was discharged to the mother's care. 4. b. At 1215 hours on 3/20/07 radiological tests of Patient #36's shunt was ordered. Documentation shows the patient went to x-ray at 1325 hours but the tests were not performed because the radiology department did not know what to do. At 1415 hours the patient was again sent to the radiology department for the tests. The test results were not available for diagnosis and/or treatment until 1700 hours; 6 and 1/2 hours after Patient #36 presented to the ED. 5. The medical record for Patient #5 documented he presented to the ED at 1139 hours on 5/11/07 with left flank pain. He was not seen by a triage nurse until three hours later to determine the severity of his symptoms. At 1448 hours, the triage nurse documented his pain was 8/10. At 1730 hours the nurse documented the first full assessment of the patient. The patient was evaluated by a physician's assistant. There was	A 406	Monitoring: • Starting July 1, 2007, Utilization Review Staff will review at least 15% of patients weekly to track and trend data from arrival to triage and arrival t medical screening exam. Time of arrival to time of discharge is tracked electronically through the *Affinity System for all patients and trended weekly.* The information goes to the Emergency Department Collaborative Committee for evaluation. The reports will go to both the ED Committee and the Quality/Performance Improvement Committee (QPIC), which will report this to the Executive Committee or Quality Council respectively, and then to the Governing Body. Positions Responsible: ED Medical Director ED Nurse Manager Immediate Actions: • The Chief Medical Officer notified the ED Medical Director that physician assistants shall not longer perform medical screening examinations (Attachment B). The ED Medical Director informed each physician assistant by email that they may no *longer perform medical screening examinations* (Attachment C). Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. Monitoring: • UR Nurse review ten randomly selected charts weekly to assess documentation that medical screening examination was performed by a physician. Deficiencies will be reported to the the ED Collaborative Committee and to the Physician Performance Improvement Committee for corrective actions if necessary. As appropriate actions will be reported to the Executive Committee and Governing Body. Position Responsible: ED Medical Director ED Nurse Manager (Additional issues for this patient are addressed under Tag 207.	6/8/07 6/8/07

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A 406	Continued From page 13 no documented evidence a physician saw Patient #5. Pain medication was not administered to Patient #5 until 2100 hours, 9 and 1/2 hours after he presented to the ER. No further treatment was provided to Patient #5 and it was documented that he eloped from the ED at 0000 hours on 5/12/07. 6. The medical record for Patient #6 identified that he came to the ED at 1812 hours on 5/11/07 for a "surgical consult for (his) umbilical hernia." He was triaged at 1845 and complained of 5/10 pain. When he was called to the treatment area four hours later he did not answer. At 0100 the nurse documented the Patient #63eft without being seen. No medical screening examination had been performed to determine if the Patient #66ad a medical emergency condition. 7. The medical record for Patient #7 showed she presented to the ED at 2045 hours on 5/11/07 for "spotting" during her pregnancy. She stated she was 2 months pregnant. At 2140 hours she was triaged and a pregnancy test was documented as positive. When the patient was called to the treatment area 2 hours later, she had left without being seen to determine if an emergency condition existed. She returned to the ED at 1306 hours on 5/14/07 with a complaint of vaginal bleeding for three days. She had 8/10 pain when triaged by the nurse at 1315. There was no documented evidence the ED nurse evaluated how much the patient was bleeding. She was not taken to the treatment area until four hours later at 1730 hours. No pain medication/intervention was given. Her medical screening exam was conducted by a physician's assistant. She passed the products of conception while having an ultrasound done and was discharged by a	A 406	406-6 Patient 6 Immediate Action: • A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of the that review, the triage policy was revised so that the triage registered nurse notifies medical provider if the patient is experiencing pain ≥ 7/10 and follows physicians order to initiate pain medication for pain relief regardless of triage acuity level (Attachment P). • The ED nurse manager provided in-service on the revised triage policy #114 (Attachment O). • The ED nurse manger provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain which requires interventions based on the pain policy. Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED nurse manager, will address deficiencies with responsible personnel. Monitoring: • The ED nurse manager or designee will review ten randomly selected charts each week to assess for appropriateness of triage acuity score based on the Emergency Severity Index, timely reassessment based on triage level and their scores adjusted accordingly, and pain intervention based on pain score. The ED Nurse Manager will address deficiencies with responsible individuals. Data from the weekly reviews will be presented to the ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary, and report it to the Quality Council and Executive Committee and as appropriate, the Governing Body. Once audits demonstrate consistency, monitoring will be limited to ten charts monthly	6/18/07 6/18/07 6/6/07

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A 406	Continued From page 14 physician at 2235 hours after having had a miscarriage. 8. Patient #2 came to the ED of the hospital on 4/30/07 at approximately 1207 hours. When triaged at 1250 hours she identified she had sharp pain of 10 on a 1-10 scale. No pain intervention were initiated in the triage area. The patient was taken to the treatment area five hours later at 1815 and received pain medication one hour later. Approximately 20 hours after she presented to the ED, at 0830 hours on 5/1/07, a general surgery consultation was provided to evaluate the acute abdominal pain for Patient #2. The closed medical record for Patient #2 revealed "Dr."at bedside. However, review of the record revealed that the general surgery consultation had been provided by a Physician Assistant (PA-C). There was no documentation to reveal that provision of emergency consultations by a PA-C was approved and consistent with the rules and regulations, the medical staff bylaws of the hospital, and the credentialing process of a mid-level practitioner. The patient was admitted to the hospital and had surgery for an exploratory laparotomy ventral hernia repair. 9. Patient #23 came to the emergency department on 4/30/07 at approximately 1000 hours for the evaluation of a known ectopic pregnancy. At 1800 hours an nursing interval note indicated that the emergency department was unable to admit Patient #23 to the hospital "due to short staff". There was no nursing or physician documentation to indicate intervention to evaluate the appropriate provision of care for Patient #23. The patient was admitted to an in-patient bed at 2100 hours.	A 406	Immediate Actions: The ED nurse manager designated a nurse educator to provide reinforced education of ED policy #114 to ensure that patients are appropriately triaged and assigned a triage acuity level based on the Emergency Severity Index. (attachment O) The nurse educator provided this supplemental training. Permanent Actions: Use of the monitoring below will assure that the deficiency remains corrected. The ED Nurse Manager will provide remedial training where a pattern of deficient practices are determined. Monitoring: The ED nurse manager or designee will review ten randomly selected charts each week to assess for appropriateness of triage acuity score based on the Emergency Severity Index, timely reassessment based on triage level and their scores adjusted accordingly, and pain intervention based on pain. Deficiencies will be addressed by the ED Nurse Manager. Data from the weekly review will be presented to the ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary, and report it to the Quality Council and Executive Committee and as appropriate, the Governing Body. Responsible Positions: Chief Nursing Officer ED Nurse Manager Immediate Actions: The Interim Chief Medical Officer directed the chairs of the Department of Medicine, Women's and Chief Health and Surgery that physician assistant will no longer be conducting medical consultations in the ED (Attachment BB). The Interim Medical Director notified all department chiefs that all Emergency Department consults must be completed within one hour of request. (Attachment S)	6/18/07 6/18/07 7/9/07

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A 406	Continued From page 14 physician at 2235 hours after having had a miscarriage. 8. Patient #2 came to the ED of the hospital on 4/30/07 at approximately 1207 hours. When triaged at 1250 hours she identified she had sharp pain of 10 on a 1-10 scale. No pain intervention were initiated in the triage area. The patient was taken to the treatment area five hours later at 1815 and received pain medication one hour later. Approximately 20 hours after she presented to the ED, at 0830 hours on 5/1/07, a general surgery consultation was provided to evaluate the acute abdominal pain for Patient #2. The closed medical record for Patient #2 revealed "Dr."at bedside. However, review of the record revealed that the general surgery consultation had been provided by a Physician Assistant (PA-C). There was no documentation to reveal that provision of emergency consultations by a PA-C was approved and consistent with the rules and regulations, the medical staff bylaws of the hospital, and the credentialing process of a mid-level practitioner. The patient was admitted to the hospital and had surgery for an exploratory laparotomy ventral hernia repair. 9. Patient #23 came to the emergency department on 4/30/07 at approximately 1000 hours for the evaluation of a known ectopic pregnancy. At 1800 hours an nursing interval note indicated that the emergency department was unable to admit Patient #23 to the hospital "due to short staff". There was no nursing or physician documentation to indicate intervention to evaluate the appropriate provision of care for Patient #23. The patient was admitted to an in-patient bed at 2100 hours.	A 406	**Permanent Action:** Use of the monitoring below will assure that the deficiency remains connected. **Monitoring:** UR nurses will review ten randomly selected medical records daily to assess documentation of consultations by attending staff only, and the timeliness with which consultations were provided. Deficiencies will be reported to the appropriate Department Chair and the Executive Committee and as appropriate the Governing Body. **Responsible Positions:** Chief Medical Officer QI Director **Immediate Actions:** A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triage policy was revised so that the triage registered nurse notifies medical provider if the patient is experiencing pain greater than 7/10 and follows physicians order to initiate pain medication for pain relief. The ED nurse manager provided in-service on the revised triage policy #114. The ED nurse manager provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain which requires interventions based on the pain policy. **Permanent Action:** The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager will address with responsible personnel deficiencies. **Monitoring:** UR nurses will review 15% randomly selected medical records weekly to assess documentation of pain administration and its results. Deficiencies will be addressed by the ED nurse manager. Data from these daily reviews will be presented to the ED Collaborative Committee. Data will also be presented to the QPIC monthly which will evaluate it, create corrective actions as necessary, and	6/21/07 6/18 – 6/19/07 6/18/07 6/18/07 6/6/07 6/21/07

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A 406	Continued From page 14 physician at 2235 hours after having had a miscarriage. 8. Patient #2 came to the ED of the hospital on 4/30/07 at approximately 1207 hours. When triaged at 1250 hours she identified she had sharp pain of 10 on a 1-10 scale. No pain intervention were initiated in the triage area. The patient was taken to the treatment area five hours later at 1815 and received pain medication one hour later. Approximately 20 hours after she presented to the ED, at 0830 hours on 5/1/07, a general surgery consultation was provided to evaluate the acute abdominal pain for Patient #2. The closed medical record for Patient #2 revealed "Dr."at bedside. However, review of the record revealed that the general surgery consultation had been provided by a Physician Assistant (PA-C). There was no documentation to reveal that provision of emergency consultations by a PA-C was approved and consistent with the rules and regulations, the medical staff bylaws of the hospital, and the credentialing process of a mid-level practitioner. The patient was admitted to the hospital and had surgery for an exploratory laparotomy ventral hernia repair. 9. Patient #23 came to the emergency department on 4/30/07 at approximately 1000 hours for the evaluation of a known ectopic pregnancy. At 1800 hours an nursing interval note indicated that the emergency department was unable to admit Patient #23 to the hospital "due to short staff". There was no nursing or physician documentation to indicate intervention to evaluate the appropriate provision of care for Patient #23. The patient was admitted to an in-patient bed at 2100 hours.	A 406	report it to the Quality Council and Executive Committee and as appropriate, the Governing Body. Once audits demonstrate consistency, monitoring will be limited to ten charts monthly. Responsible Positions: Chief Nursing Officer ED Nurse Manager QI Director Immediate Actions: A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of the review, the triaging process was re-designed to provide for a timelier medical exam and treatment. This process includes the following: (Attachment P) • The triage nurse and registration clerk are co-located so that the triaging process and the registration process can occur simultaneously. • The physician will be available to the triaging area to perform immediate medical screening examinations for patients who are identified as a Level 3. Upon completion of the medical screening examination, based on the patient's clinical presentation, tests and treatments (including pain management (will be ordered and carried out.. • Patients that are identified as a level 1 and 2 at the time of triage will be brought back to the emergency treatment area. At the time of arriva *Monitoring:* PFS personnel will use the central log to track and trend wait times from triage to medical screening examination and ED length of stay. Data will be presented to the ED Collaborative Committee. Average wait times from triage to medical screening examination and length of stay that exceed expectations will prompt triage process review; additional changes may be instituted. The data will also be presented to the QPIC monthly which will evaluate it, create corrective actions as necessary, and report it to the Quality Council and Executive Committee and as appropriate to the Governing Body.	6/18/07

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A 406	Continued From page 15 10. Patient #3 came to the emergency department of the hospital at approximately 2040 hours on 4/30/07. Patient #3 stated that he was seeing aliens and devils. He was dropped off by his family. At triage the nurse documented the patient had suicidal ideations with a plan to drink bleach. The nurse triaged the patient as a category 3 (stable major illness) and left him in the lobby for over one hour before taking him back to the treatment area. Patient #3 was evaluated by the emergency department physician at 0500 hours on 5/1/07, a delay of almost 7 hours. No psychiatric treatment or consultation was provided. Approximately 6 hours later, at 1055 hours on 5/1/07, an evaluation by a mental health professional was requested. The mental health evaluation was not completed until four hours later at 1500 hours; 17 hours after he presented to the ED: The mental health professional determined the Patient #26enied being suicidal at the time of the evaluation. Patient #3 was discharged home at 2100 hours without receiving treatment. The hospital thus failed to ensure that the provision of emergency services had been provided within timeframes consistent with acceptable safety for psychiatric patients. 11. a. Patients #66, #67, #68, #62, #63, #64, and #65 were evaluated on 5/30 or 5/31/07 at triage and sent to the Urgent Care area of the emergency department. Each patient was examined and treated by a Physician Assistant, PA-C. When reviewed, each medical record revealed that the patients had been evaluated, treated and discharged from the Urgent Care of the hospital prior to the time of supervision or monitoring by the emergency department physician. The facility failed to ensure that direct	A 406	Immediate Actions: The ED nurse manager counseled the responsible nurse for not following the triage policy. The ED nurse manager designated a nurse educator to provide reinforced education of ED policy #114 to ensure that patients are appropriately triaged with and assigned a triage acuity level based on the Emergency Severity Index. 6/18/07 Monitoring: The ED nurse manager or designee will review ten randomly selected charts each week, assess for appropriateness of triage acuity score based on the Emergency Severity Index, timely reassessment based on triage level and their scores adjusted accordingly, and pain intervention based on pain. Deficiencies will be addressed by the ED nurse manager. Data from the weekly reviews will be presented to the ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary, and report it to the Quality Council and Executive Committee and as appropriate, the Governing body. A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of the review, the triaging process was re-designed to provide for a timelier medical screening exam and treatment. This process includes the following: • The triage nurse and registration clerk are co-located so that the triaging process and the registration process can occur simultaneously. • The physician will be available to the triaging area to perform immediate medical screening examinations for patients who are identified as a Level 3. Upon completion of the medical screening examination, based on the patient's clinical presentation, tests and treatments (including pain management) will be ordered and carried out. • Patients who are identified as a level and 2 at the time of triage will be brought back to the emergency treatment area. At the time of arrival, the ED charge nurse will notify the physician of the patient's arrival by placing the patient's pseudo name on the white board along with the	

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A 406	Continued From page 15 10. Patient #3 came to the emergency department of the hospital at approximately 2040 hours on 4/30/07. Patient #3 stated that he was seeing aliens and devils. He was dropped off by his family. At triage the nurse documented the patient had suicidal ideations with a plan to drink bleach. The nurse triaged the patient as a category 3 (stable major illness) and left him in the lobby for over one hour before taking him back to the treatment area. Patient #3 was evaluated by the emergency department physician at 0500 hours on 5/1/07, a delay of almost 7 hours. No psychiatric treatment or consultation was provided. Approximately 6 hours later, at 1055 hours on 5/1/07, an evaluation by a mental health professional was requested. The mental health evaluation was not completed until four hours later at 1500 hours; 17 hours after he presented to the ED. The mental health professional determined the Patient #26enied being suicidal at the time of the evaluation. Patient #3 was discharged home at 2100 hours without receiving treatment. The hospital thus failed to ensure that the provision of emergency services had been provided within timeframes consistent with acceptable safety for psychiatric patients. 11. a. Patients #66, #67, #68, #62, #63, #64, and #65 were evaluated on 5/30 or 5/31/07 at triage and sent to the Urgent Care area of the emergency department. Each patient was examined and treated by a Physician Assistant, PA-C. When reviewed, each medical record revealed that the patients had been evaluated, treated and discharged from the Urgent Care of the hospital prior to the time of supervision or monitoring by the emergency department physician. The facility failed to ensure that direct	A 406	Committee and the Quality Council and Executive Committee, and when appropriate the Governing Body. Once audits demonstrate consistency, monitoring will be limited to ten charts monthly.	

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A 406	Continued From page 16 supervision of a mid-level practitioner had been provided. The medical record for each Patient #6ailed to demonstrate a timed entry by the emergency department physician. When interviewed on 5/31/07 at approximately 1030 hours, the PA-C readily admitted that a medical screening examination, provided by the PA-C was unsupervised. When reviewed, there was no documentation in the rules and regulations, or medical staff by laws delineating such privileges for the PA-C. There was no documentation present in the PA-C privileging forms to assess their qualifications and competence to provide medical screening examinations in the emergency department and/or to determine if an emergency medical condition existed. 11. b. Additional review of medical records revealed Patients #5, #7, #9 and #15 had their medical screening examination in the main emergency room treatment area. The medical records showed the exams were performed by PA-Cs. There were no timed co-signatures of the records by a supervising physician. 12. The medical record for Patient #9 showed she presented to the ED at approximately 1400 hours on 4/30/07 complaining of having a glass object "stuck" in her vagina. She complained of moderate aching pain. The nurse documented a PA-C saw the patient in triage at 1540 hours, but there was no documentation by the PA-C about the determination if an emergent medical condition existed. There was no treatment ordered or provided for the patient's pain. There was no documented re-assessment of Patient #9, until approximately 6 and 1/2 hours later, when a nurse saw her. A gynecological examination of the patient was ordered by the PA-C at	A 406	A review of this patient file reflects that the notes of a medical screening examination by a physician, as well as a consultation by a gynecologist did occur in this case and were documented in the medical record, but were misfiled under an outpatient services tab. However, because some delay in providing the screening examination and consultation occurred, the following actions are proposed. Immediate Actions: A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of the review, the triaging process was re-designed to provide for a timelier medical screening exam and treatment. This process includes the following: • The triage nurse and registration clerk are co-located so that the triaging process and the registration process can occur simultaneously. • The physician will be available to the triaging area to perform immediate medical screening examinations for patients who are identified as a Level 3. Upon completion of the medical screening examination, based on the patient's clinical presentation, tests and treatments (including pain management) will be ordered and carried out	6/212/07

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A 406	Continued From page 16 supervision of a mid-level practitioner had been provided. The medical record for each Patient #6ailed to demonstrate a timed entry by the emergency department physician. When interviewed on 5/31/07 at approximately 1030 hours, the PA-C readily admitted that a medical screening examination, provided by the PA-C was unsupervised. When reviewed, there was no documentation in the rules and regulations, or medical staff by laws delineating such privileges for the PA-C. There was no documentation present in the PA-C privileging forms to assess their qualifications and competence to provide medical screening examinations in the emergency department and/or to determine if an emergency medical condition existed. 11. b. Additional review of medical records revealed Patients #5, #7, #9 and #15 had their medical screening examination in the main emergency room treatment area. The medical records showed the exams were performed by PA-Cs. There were no timed co-signatures of the records by a supervising physician. 12. The medical record for Patient #9 showed she presented to the ED at approximately 1400 hours on 4/30/07 complaining of having a glass object "stuck" in her vagina. She complained of moderate aching pain. The nurse documented a PA-C saw the patient in triage at 1540 hours, but there was no documentation by the PA-C about the determination if an emergent medical condition existed. There was no treatment ordered or provided for the patient's pain. There was no documented re-assessment of Patient #9, until approximately 6 and 1/2 hours later, when a nurse saw her. A gynecological examination of the patient was ordered by the PA-C at	A 406	• Patients who are identified as a Level 1 and 2 at the time of triage will be brought back to the emergency treatment area. At the time of arrival, the ED charge nurse will notify the physician of the patient's arrival by placing the patient's pseudo name on the white board along with the patient's priority number. The physician will acknowledge the patient by initialing the white board and will perform the medical screening examination as soon as possible. If the patient's condition is critical, the RN will verbally notify the physician. Permanent Action: The monitoring process set forth below will be used to assure the continued effectiveness of the corrective actions. The ED Medical director will assure the correction of deficient practices which are disclosed by the monitoring. Monitoring: • PFS personnel will use the central log to track and trend wait times from triage to medical screening examination and ED length of stay. Data will be presented to ED Collaborative Committee at their monthly meeting. Average wait times from triage to medical screening examination and length of stay that exceed expectations will prompt triage process review; additional changes may be instituted. The data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary, and report it to the Quality Council and Executive Committee and as appropriate to the Governing Body. • UR nurses will review ten randomly selected medical records weekly to track the time from triage to medical screening examination. Data from these daily reviews will be presented to the ED Collaborative Committee and the process will be re-evaluated as a result of this review. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary, and report it to the Quality Council and Executive Committee and as appropriate, the Governing Body. Once audits demonstrate consistency, monitoring will be limited to ten charts monthly. Position Responsible: ED Medical Director	

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A 406	Continued From page 17 approximately 2100 hours. The nurse documented an exam was done by a physician but there was no documentation by a member of the medical staff of the patient's condition and/or treatment received. The patient was discharged at 2230 hours. The discharge instructions were written by the PAC. 13. Additional review of the medical record for Patient #29 identified she came to the ED with the paramedics at approximately 1700 hours on 4/28/07, after taking 10 Elavil pills (antidepressant) in a suicide attempt. There was a one-hour delay in the medical screening examination and any stabilizing treatment. The patient was later admitted to the hospital then transferred to a psychiatric hospital.	A 406	• Patients who are identified as a Level 1 and 2 at the time of triage will be brought back to the emergency treatment area. At the time of arrival, the ED charge nurse will notify the physician of the patient's arrival by placing the patient's pseudo name on the white board along with the patient's priority number. The physician will acknowledge the patient by initialing the white board and will perform the medical screening examination as soon as possible. If the patient's condition is critical, the RN will verbally notify the physician. Permanent Action: The monitoring process set forth below will be used to assure the continued effectiveness of the corrective actions. The ED Medical director will assure the correction of deficient practices which are disclosed by the monitoring.	
A 407	489.24(d)(1-3) STABILIZING TREATMENT (1)Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either, within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition; or for transfer of the individual to another medical facility in accordance with paragraph (e) of this section. (2) Exception: Application to inpatients. (i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has	A 407	Monitoring: • PFS personnel will use the central log to track and trend wait times from triage to medical screening examination and ED length of stay. Data will be presented to ED Collaborative Committee at their monthly meeting. Average wait times from triage to medical screening examination and length of stay that exceed expectations will prompt triage process review; additional changes may be instituted. The data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary, and report it to the Quality Council and Executive Committee and as appropriate to the Governing Body. • UR nurses will review ten randomly selected medical records weekly to track the time from triage to medical screening examination. Data from these daily reviews will be presented to the ED Collaborative Committee and the process will be re-evaluated as a result of this review. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary, and report it to the Quality Council and Executive Committee and as appropriate, the Governing Body. Once audits demonstrate consistency, monitoring will be limited to ten charts monthly.	

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A 407	Continued From page 18 satisfied its special responsibilities under this section with respect to that individual (ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment. (iii) A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation. (3) Refusal to consent to treatment. A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's behalf) does not consent to the examination or treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both. This STANDARD is not met as evidenced by: Based on medical record reviews, policy and procedure reviews, review of hospital documentation and staff interviews, the hospital failed to transfer two patients, with an emergency medical condition to another medical facility for	A 407		

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A 407	Continued From page 19 stablizing treatment (Patients #36 and #50). In addition, the hospital failed to ensure prompt stabilizing treatment was provided for ten of 68 sampled patients (Patients #2, #3, #5, #7, #9, #26, #29, #36, #50, #69). Findings: On 5/31/07, the hospital's EMTALA Compliance Policy and Procedure (P&P HA 316) defined an emergency medical condition as one manifesting itself by acute symptoms of such severity in which the absence of immediate medical attention could be expected to place the health of the individual in serious jeopardy. The P&P identified emergency medical conditions included severe pain, psychiatric disturbances and and/or symptoms of substance abuse. It specified that a medical screening examination was a continuous process reflecting ongoing monitoring until the individual was stabilized or appropriately transferred. It defined stabilization of the patient as the point where there was a reasonable certainty that the patient's condition would not deteriorate medically. With respect to psychiatric patients it was defined as either the time when they no longer posed a danger to themselves or others or when it had been determined there was no underlying organic cause for the mental disturbance. Number 105 of the medical staff rules and regulations stated. "Any patient evaluated in the emergency room ... who is known or suspected to be suicidal, otherwise self injurious, or has taken a chemical overdose shall have psychiatric consultation." Number 69 of the medical staff rules and regulations stated that patients were to be seen within one hour for emergency consultations. The hospital staff failed to follow these patient care directives.	A 407	Immediate Actions: No longer have inpatient psych. PHRT is responsible for conducting evaluations. Initial assessment by ED Medical Director and once medically cleared, PMRT contacted.	

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A 407	Continued From page 20 Patient #50 presented to the ED (emergency department) on 2/28/07 at 0950 hours, with a chief complaint of headache (comes and goes) with occasional nausea. At the time of triage, 1003 hours, the patient described that he was experiencing severe pain, that scored nine out of 10, on a scale of one to 10, with 10 being the most severe. The patient described that the pain was located at the back of his head and that it was relieved by vomiting. The patient was assigned a triage acuity of three. Per hospital policy, an acuity of three indicated the patient had a major illness or injury, but was stable. At 1250 hours, Patient #50 was taken to the treatment area. Nursing assessment at that time revealed " steady gait " , pupil sizes of 33 and 31 mm. A Glascow Coma Scale score of 15 was recorded (a standardized series of observations reflecting speech, pain, orientation and speech. A score of 15 is normal). Patient #50 was assessed by the emergency department physician, at which time "paraspinal tenderness" was noted, but no " Neuro" changes or " Psych" abnormalities recorded. A blood count revealed 16.4 gms. of hemoglobin and a white count of 10,800 (upper normal range). Morphine 4 mg was administered in the emergency department, however, the results of the medication administration was not recorded. A CT head scan was ordered by the ED physician. At 1550 hours Patient #50 was taken to CT. The report revealed, "significant ventricular dilatation with periventricular changes consistent with subependymal edema. This may be related to a	A 407	Immediate Actions: A protocol has been established to require that all patients with specific neurosurgical clinical conditions receive timely transfer (Attachment). • The emergency medicine attending (ED physician) at MLK-H will identify patients requiring neurosurgical intervention based on specific guidelines. • The ED physician or the Patient Flow Manager will then contact the MAC operator, informing him/her of the patient needing transfer. • MAC determines the accepting/receiving facility based on a rotation schedule it maintains. • MAC will contact the Patient Flow Manager at the receiving facility regarding the need for the transfer. • The Patient Flore Manager at the receiving facility promptly contacts the neurosurgeon on cal and arranges the physician-to-physician contact. ED physician at MLK-H speaks directly with neurosurgeon at the receiving facility and provided a brief summary of the patient's findings. • Any clinical suggestions by the receiving neurosurgeon, which are within the capability of the hospital and the scope of practice of the ED physician, will be incorporated into the pre-transfer plan of care. • The respective facility Patient Flow Managers shall work with MAC to coordinate the transfer via ACLS transport. • All appropriate and competed documents and imaging studies shall accompany the patient. • If the ED physician determines that there is ANY impediment to the transfer he/she shall contact the Chief Medical Officer at the receiving facility to facilitate the transfer. The Interim Chief Medical Officer counseled the neurologist regarding lack of written note for consultation and documentation of ongoing assessment. Permanent Action: With respect to all patient transfers, regardless of patient diagnosis, a transfer log is maintained by MLK-H Patient Flow Manager. A mullidisciplinary group meets Monday through Friday to review all transfers that have taken place based on this log, to resolve any issues identified from completed transfers	6/15/07

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A 407	Continued From page 21 heterogeneous mass near the region of the pineal with caudal extension to a level near the proximal fourth ventricle." The scan revealed a brain tumor measuring approximately 2.5 cm. compressing the internal circulation of fluid in the brain resulting in internal swelling from dilatation of the ventricular system of the brain. An MRI image of the brain was recommended and completed. This confirmed the presence of a tumor mass in the region of the pineal gland. Moderate dilatation of the ventricular system of the brain was noted. A handwritten note by the ED physician noted that Neurosurgery was not available at the hospital, "will arrange MAC transfer". (The MAC is the medical alert center for Los Angeles County. This is the central clearing house for all Los Angeles County hospitals.) However, there was no written documentation that physician to physician contact had been initiated. A clinical impression of "Acute Obstructive Hydrocephalus" was recorded. A physician order for a neurosurgery consult was written at 1653 hours on 2/28/07. A "Neurology Consultation" handwritten by a Physician Assistant (PA-C) identified that the patient was seen for evaluation at 1720 hours. The consultation revealed no neurological defects or alteration in mental status for Patient #50. The consult described symptoms of dizziness, nausea, headache and vomiting. The consultation, provided by the PA-C, was then countersigned by the attending neurology physician at 1900 hours. No written note was provided by the neurology physician. The medical record failed to contain documented evidence that the neurologist had actually examined Patient #50. This finding was in violation of the Medical	A 407	that have taken place based on this log, to resolve any issues identified from completed transfers, to facilitate patients waiting for transfer, and to update the status of patients requiring transfers. Any neurosurgical patients who are pending transfer will be reviewed as part of this process. • MLK-H has identified a medical administrative director in charge of patient flow. This Patient Flow Manager notifies Medical Administration whenever there are impediments to transferring a patient, including a neurosurgical patient, in a timely manner. The medical administrative staff will assure that there is high-level physician contact with potential receiving institutions in an effort to expedite transfer. **Monitoring:** The Patient Flow Manager maintains a log of patient transfers. Data regarding patient transfers is aggregated and presented to QPIC and to the Quality Council and Executive Committee and then to the Governing Body where appropriate. The ED nurse manager counseled the RN who gave the morphine 4 mg, but did not document the results of the medication administration. ED nurse manager educated all ED registered nurses on the requirements to record the results of pain medication administration. **Permanent Actions:** The monitoring plan set forth below will be used to assure the continuing effectiveness of the corrective actions. ED nurse manager will address deficiencies with responsible personnel. **Monitoring:** Utilization Review nurses will randomly select ten ED charts weekly to assess for documentation of pain assessment and reassessment. The results of the audit are reported to QPIC. Deficiencies will be reported to the ED nurse manager for a corrective action plan; then reported to the Executive Committee and the Governing Body as appropriate. For the ED physicians, the smart chart (a physician documentation record, which is a tool used to assure consideration of important clinical questions was	3/07

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A 407	Continued From page 22 Staff rules and regulations requiring a written note. The consultation request form revealed that "Stat MAC transfer to a facility with neurosurgical service" was required. A written order for "MAC transfer to Neurosurgical facility was provided at 1717 hours by the attending ED physician. There was, however, no written documentation that any physician had actually spoken with or discussed the emergent clinical situation of Patient #50 with a proposed receiving hospital to facilitate transfer for Patient #50. Documents contained in the medical record revealed that Patient #50 signed a transfer consent on 2/28/07. At 0350 hours on March 1, 2007, nursing notes revealed that Patient #50 was administered Dilaudid (narcotic pain medication) by IVP (intravenously push). There was no documented evidence that a ED physician had examined or assessed the neurological status of Patient #50. A nursing re-assessment performed at 0550 hours revealed that a neurocheck had been performed and the headache pain of Patient #50 had improved. Additional nursing assessments were performed at 0730, 0900,1100, 1300, 1500, and 1830 hours. These nursing assessments documented no change in the status of Patient #50 These assessments indicated that Patient #50 was able to move all four extremities and remained alert. No physician assessments were documented. Patient #50 remained in the ED until 3/3/07. Review of the medical record revealed that the patient was assessed by nursing staff and continued to received Dilaudid and morphine to	A 407	implemented to improve physician documentation and to capture encounter times. The ED Medical Director informed ED physicians at a department meeting, and followed-up with a written directive to all ED physicians, that they were responsible for assessing all active patients and patients waiting for transfer at the beginning of each shift. They were also informed of their responsibility to meet with oncoming physicians at the end of shift to *provide appropriate information as part of the pass on* process. Physicians were also reminded to document the patient's condition at change of shift and to document that the patient's care was transferred to the oncoming physician (Attachment). 6/9/07 An outside consultant l provided reinforcing education to all ED nursing leadership on the importance of patient advocacy, particularly as it relates to chain of command and nurse-to-physician communication. Permanent Actions: The monitoring process set forth below will be used to assure the continuing effectiveness of the corrective actions. The ED Medical Director will address deficiencies with responsible personnel. Monitoring: Ten charts will be randomly reviewed each week to validate the presence of attendings and validate the documentation of physician involvement at least at the change of shift. Deficiencies will be addressed with the ED Director, Results of these audits will be provided to the Physician Performance Improvement Committee which will review and create corrective action as necessary. This data will then be reported to Medical Executive Committee and to the Governing Body as appropriate. Immediate Actions: The Interim Chief Medical Officer ordered all MLK Department Chiefs to discontinue the practice of using *Physician Assistants for consultations in the ED.* All ED consultations will be performed by an attending physician (Attachment). 6/14/07 The ED nurse manager provided a letter instructing al IED RNs that Physician Assistants cannot provide consults (Attachment). 6/19/07 The Interim Chief Medical Officer instructed all Department Chiefs to ensure that all attending physicians are aware of the need to document their 7/5/07

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A 407	Continued From page 23 control his headache pain. The nursing pain assessments included only a numerical score to identify the intensity of pain but failed to identify pain radiation, quality (ache, throbbing, sharp, dull, burning) and constancy as required by established hospital policy. The medical record failed to provide documented evidence that ED physicians provided on-going assessments and care. Except for the initial consult, the neurologist did not see the patient again. On 3/3/07 at 0725 hours, nursing documentation identified that Patient #50 complained of occipital headache pain. Intensity of pain was recorded as 5/10. The patient was not given pain medication nor were non-medication interventions provided. Nursing documentation further identified that no deficits were noted. However, the very next sentence stated c/o (complaint of) blurred vision when ambulating. The patient was not evaluated for the neurological symptom by a physician. At 1100 hours, Patient #50 complained of increased head pain. The patient identified the intensity of pain as being 9/10 (severe). The patient received Dilaudid 1 mg. IV for pain. Although a physician order was obtained for the pain medication, the patient's medical record failed to contain documented evidence that the ED physician evaluated the patient. At 1150 hours, the patient and his family indicated that after three days, they were tired of waiting for transfer to another hospital. Patient #50 signed out AMA (against medical advise) to seek treatment elsewhere. The "Leaving Hospital against Medical Advice" form was noted to be incomplete. In addition, the medical record failed to contain documented evidence that at the time	A 407	consultations (Attachment). Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The chair of the relevant consulting department will address with responsible personnel deficiencies. Monitoring: For the next 30 days, Monday through Friday, UR RNs will review ten randomly selected open medical records in the ED to validate that consults were performed by a physician and that there is a consulting physician's note and that the consultation was timely. The Chair of the relevant department will be notified of discrepancies for immediate corrective action. Immediate Actions: The ED nurse manager provided education to all ED RNs on discharge assessments and documentation. The ED Medical Director provided education to ED MDs on the elopement and AMA policy, which includes the requirement to document the patient's level of capacity and the discussion with the patient regarding the risks and benefits of staying in the hospital. The education addressed that patients should be provided with instructions on follow-up care (Attachment). Permanent Actions: The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED nurse manager, or the ED medical director as appropriate, will address deficiencies with responsible personnel. Monitoring: • Ten randomly selected charts will be reviewed each week to validate completion of discharge assessments by MDs and RNs. Deficiencies will be discussed with appropriate supervisor and results will be reported to QPIC, which will review and create corrective action as necessary. This data then be reported to the Quality Council and Executive Committee and to the Governing Body	

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A 407	Continued From page 24 of discharge, the patient had been assessed by a physician or had received discharge instructions. On 6/1/07 and 6/5/07 discussions with hospital staff regarding the care of Patient #50 and quality assurance, identified that the medical care received by Patient #50 was deemed to be appropriate. The hospital was requested to provide any and all documentation related to the patient's care as well as any quality of care reviews. A case review summary for Patient #50 was received at 1340 hours on 6/5/07. The case review confirmed a failure of the ED physicians to document assessments of Patient #50 for three days. Further review of the summary identified that there was a system wide plan to provide neurosurgical services and to streamline the transfer process of patients between hospitals. Patient #50 was a pending transfer to a higher level of care on 3/3/07 prior to leaving the hospital against medical advice. As of 6/7/07, the plan had not been implemented. 2. Patient #69 presented to the emergency department on 3/8/07 at 2242 hours, with a chief complaint of stomach pain for the past two weeks. The nurse documented that the pain was in all four quadrants and radiated in to the patient's back. It was documented that the patient had multiple episodes of nausea and vomiting today. The patient identified her pain as being severe with a score of 10 out of 10. The patient identified that the pain she was experiencing was constant and that nothing provided relief. The pain was further described as aching and burning with a pressure sensation. Nursing documentation revealed that the patient was	A 407	as appropriate • Monthly, the HIM director or designee will report data on the number of patients "Left Before Seen" to the ED Collaborative Committee and QPIC, which will review and create corrective action as necessary. This data will then be reported to the Quality Council and Executive Committee and to the Governing Body as appropriate. • For the next two months or until stable QI nurses will review ten randomly selected closed medical records of ED patients who left AMA to verify that documentation conforms to the policy. Deficiencies will be reported to the ED Collaborative Committee, which will create corrective action as necessary. This data will be reported to the Performance Improvement Committee and to the Executive Committee and Governing Body as appropriate. • Immediate Actions: A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triage policy was revised so that the triage registered nurse notifies medical provider if the patient is experiencing pain greater than 7/10 and follows physicians order to initiate pain medication for pain relief regardless of triage acuity level. The ED nurse manger provided in-service on the revised triage policy #114. The ED nurse manager provided education to all ED RNs on the requirement to notify physicians of all patient waiting to be seen that are experiencing pain which requires interventions based on the pain policy.	6/21/07 6/5/-6/14/07

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A 407	Continued From page 25 moaning and had facial grimacing. Vital signs were recorded as Temperature 102.8 degrees, heart rate 97, respirations 24 and blood pressure was 133/59. No treatment was provided to alleviate pain or reduce the patient's fever at the time of triage. The patient was assigned a triage category of 3. Category or Level 3 patients are described as having a stable major injury or illness. Two hours later, at 0040 hours, Patient #69's vital signs were re-assessed. The patient had a temperature of 102.4 degrees, heart rate 102, respirations 20 and blood pressure was recorded as 118/62. The patient continued to experience severe abdominal pain. No treatments were provided in the triage area. At 0110 hours, the patient was transferred to the treatment area. The patient continued to have severe pain, recorded as 7/10. The patient received Tylenol 650 mg. and was placed on oxygen by mask. At 0220 hours, the patient was described to have decreased pain. At 0400 hours, nursing documentation revealed that the patient had no orders for care and was waiting for the physician assistant. This was approximately three hours after she was taken to the treatment area of the ED. Patient #69 was not evaluated by a physician until 0530 hours The patient was described as having a fever and was in moderate to severe distress. The patient continued to experience severe pain and nausea. The patient experienced severe pain throughout her ED stay. At 0950 hours, 11 hours after presenting to the ED, the patient was transferred to surgery	A 407	**Permanent Actions:** The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED nurse manager, will address deficiencies with responsible personnel. **Monitoring:** The ED nurse manager or designee will review ten randomly selected charts each week to assess ED patient for appropriateness of pain intervention based on pain score. Deficiencies will be addressed by the ED nurse manager. Data from the weekly reviews will be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary, and report it to the Quality Council and Executive Committee and as appropriate, the Governing Body. **Positions Responsible:** ED Nurse Manager	

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A 407	Continued From page 26 services to undergo an exploratory laparotomy. 3. The medical record for Patient #26 documented the teenager presented to the emergency department (ED) at 2355 hours on 2/12/07 with right abdominal pain. He was triaged by the nurse and determined to have pain of 10 on a 1-10 scale (10/10). His oxygen saturation level was 100%, his pulse 95 respirations were 18 and his blood pressure was 113/69. At 0040 hours the nurse documented the patient was complaining of difficulty breathing. The nurse documented he had wheezing in his lungs, his respiratory rate was 22 , blood pressure was 135/70, oxygen saturation was 97% and that he was anxious and restless. There was no documentation about why he was left in the lobby of the ED. No pain medication or other pain relieving interventions were provided. There was no re-assessment of the patient until he was taken to a treatment area five hours later. At 0530 hours on 2/13/07 his pain was 8/10. At 0645 hours laboratory tests and pain medication were ordered for Patient #26. The pain medication was administered at 0840 hours; approximately 8 and 1/2 hours after he presented to the ED. The laboratory test results were not available until 2100 hours. This was approximately 14 hours after they were ordered and 19 hours after Patient #26 came to the ED. There was no documented evidence the nursing or medical staff were following-up to ensure the laboratory test results were obtained. During interviews on 6/1/07 medical staff stated this patient "fell through the cracks." 4. a. The medical record for pediatric Patient #36 showed she presented to the emergency department at 1030 hours on 3/20/07 for	A 407	**Immediate Actions** • A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of the review, the triage policy was revised so that the triage registered nurse notifies medical provider if the patient is experiencing pain ≥ 7/10 and follows physicians order to initiate pain medication for pain relief. (Attachment O). • The ED nurse manager provided in-service on the revised triage policy #114. (Attachment O) • The ED nurse manger provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain which requires interventions based on the pain policy. (Attachment N&B) **Permanent Actions:** The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED nurse manager, will address deficiencies with responsible personnel. **Monitoring:** The ED nurse manager or designee will review ten randomly selected charts each week to assess ED patients for appropriateness of pain intervention based on pain score. Deficiencies will be addressed by the ED Nurse Manager. Data from the weekly reviews will be presented to ED Collaborative Committee and will also be presented to the Performance Improvement Committee monthly, which will evaluate it, create corrective actions as necessary, and report it to the Executive Committee and as appropriate, the Governing Body. **Positions Responsible:** Chief Nursing Officer ED Nurse Manager	6/18/07 6/18/07 6/19/07 7/5/07

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A 407	Continued From page 27 vomiting, lethargy, cough and congestion. She had a history of a ventriculoperitoneal shunt for hydrocephalus and began to feel bad after a visit to the dentist. Documentation shows the presence of a shunt malformation and/or infection was being ruled out. A neurology consult was ordered. At 1230 the physician's assistant (PA) saw the patient to perform the neurology consultation. There was no documented evidence a neurologist saw the patient; however, the PA documented the recommended plan, in consultation with the neurologist, would be evaluation and management by a neurosurgeon on an urgent basis to assess the functioning of the shunt. Since neurosurgeons were not available at the hospital the PA recommended transfer to another hospital. The child was in the emergency department until 2200 hours but there was no documented evidence a neurosurgeon was contacted or that efforts were made to transfer the patient to a hospital with this service available. The patient was discharged to the mother's care. 4. b. At 1215 hours on 3/20/07 radiological tests of Patient #36's shunt was ordered. Documentation shows the patient went to x-ray at 1325 hours but the tests were not performed because the radiology department did not know what to do. At 1415 hours the patient was again sent to the radiology department for the tests. The test results were not available for diagnosis and/or treatment until 1700 hours; 6 and 1/2 hours after Patient #36 presented to the ED. 5. The medical record for Patient #5 documented he presented to the ED at 1139 hours on 5/11/07 with left flank pain. He was not seen by a triage nurse until three hours later to determine the	A 407	Immediate Actions A protocol has been established to require that all patients with specific neurosurgical clinical conditions receive timely transfer, (Attachment) ➢ The emergency medicine attending (ED physician) at MLK-H will identify patients requiring neurosurgical intervention based on specific guidelines. ➢ The ED physician or the Patient Flow Manager will then contact the MAC operator, informing him/her of the patient needing transfer. ➢ MAC determines the accepting/receiving facility based on a rotation schedule it maintains. ➢ MAC will contact the Patient Flow Manager at the receiving regarding the need for the transfer. ➢ The Patient Flow Manager at the receiving facility promptly contacts the neurosurgeon on call and arranges the physician-to physician contact. ED physician at MLK-H speaks directly with neurosurgeon at the receiving facility and provided a brief summary of the patient's findings. ➢ Any clinical suggestions by the receiving neurosurgeon, which are within the capability of the hospital and the scope of practice of the ED physician, will be incorporated into the pre-transfer plan of care. ➢ The respective facility Patient Flow Managers shall work with MAC to coordinate the transfer via ACLS transport. ➢ All appropriate and completed documents and imaging studies shall accompany the patient. ➢ If the ED physician determines that there is ANY impediment to the transfer he/she shall contact the Chief Medical Officer at the receiving facility to facilitate the transfer. ➢ MLK-H has identified a medical administrative Director in charge of patient flow. This Patient Flow Manager notifies the medical administrative Director whenever there are impediments to transferring a patient, including a neurosurgical patient, in a timely manner. The medical administrative Director will assure that there is high-level physician contact with potential receiving institutions in an effort to expedite transfer.	

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A 407	Continued From page 27 vomiting, lethargy, cough and congestion. She had a history of a ventriculoperitoneal shunt for hydrocephalus and began to feel bad after a visit to the dentist. Documentation shows the presence of a shunt malformation and/or infection was being ruled out. A neurology consult was ordered. At 1230 the physician's assistant (PA) saw the patient to perform the neurology consultation. There was no documented evidence a neurologist saw the patient; however, the PA documented the recommended plan, in consultation with the neurologist, would be evaluation and management by a neurosurgeon on an urgent basis to assess the functioning of the shunt. Since neurosurgeons were not available at the hospital the PA recommended transfer to another hospital. The child was in the emergency department until 2200 hours but there was no documented evidence a neurosurgeon was contacted or that efforts were made to transfer the patient to a hospital with this service available. The patient was discharged to the mother's care. 4. b. At 1215 hours on 3/20/07 radiological tests of Patient #36's shunt was ordered. Documentation shows the patient went to x-ray at 1325 hours but the tests were not performed because the radiology department did not know what to do. At 1415 hours the patient was again sent to the radiology department for the tests. The test results were not available for diagnosis and/or treatment until 1700 hours; 6 and 1/2 hours after Patient #36 presented to the ED. 5. The medical record for Patient #5 documented he presented to the ED at 1139 hours on 5/11/07 with left flank pain. He was not seen by a triage nurse until three hours later to determine the	A 407	The Interim Chief Medical Officer notified all pediatric and pediatric urgent care physicians that they must follow the "Neurosurgical Patients at MLK-Harbor Hospital" transfer process for any pediatric patient presenting in the Pediatric Urgent Care with a potential neurosurgical emergency. With respect to all patient transfers, regardless of patient diagnosis, a transfer log is maintained by MLK-H Patient Flow Manager. A multidisciplinary group meets Monday through Friday to review all transfers that have taken place based on this log, to resolve any issues identified from completed transfers, to facilitate patients waiting for transfer, and to update the status of patients requiring transfer. Any neurosurgical patients who are pending transfer will be reviewed as part of this process. Monitoring: The Patient Flow Manager maintains a log of patient transfers. Data regarding patient transfers is aggregated and presented to Performance Improvement Committee and to the Executive Committee and then to the Governing Body where appropriate. Each month for the next six months the medical records of a minimum of 10 patients, or, if fewer, 100% of pediatric patients presenting to the Pediatric Urgent care with a neurosurgery diagnosis will be reviewed by the Chairman of Pediatrics for compliance. Deficiencies will be addressed by the Chairman of Pediatrics and referred to the Medicine Performance Improvement Committee, as appropriate, and to the Physician Performance Improvement Committee for corrective actions if necessary. As appropriate actions will be reported to the Executive Committee and Governing Body.	

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A 407	Continued From page 28 severity of his symptoms. At 1448 hours, the triage nurse documented his pain was 8/10. At 1730 hours the nurse documented the first full assessment of the patient. The patient was evaluated by a physician's assistant. There was no documented evidence a physician saw Patient #5. Pain medication was not administered to Patient #5 until 2100 hours, 9 and 1/2 hours after he presented to the ER. No further treatment was provided to Patient #5 and it was documented that he eloped from the ED at 0000 hours on 5/12/07. 6. The medical record for Patient #7 showed she presented to the ED at 2045 hours on 5/11/07 for "spotting" during her pregnancy. She stated she was 2 months pregnant. At 2140 hours she was triaged and a pregnancy test was documented as positive. When the patient was called to the treatment area 2 hours later, she had left without being seen to determine if an emergency condition existed. She returned to the ED at 1306 hours on 5/14/07 with a complaint of vaginal bleeding for three days. She had 8/10 pain when triaged by the nurse at 1315. There was no documented evidence the ED nurse evaluated how much the patient was bleeding. She was not taken to the treatment area until four hours later at 1730 hours. No pain medication/intervention was given. Her medical screening exam was conducted by a physician's assistant. She passed the products of conception while having an ultrasound done and was discharged by a physician at 2235 hours after having had a miscarriage. 7. Patient #2 came to the ED of the hospital on 4/30/07 at approximately 1207 hours. When triaged at 1250 hours she identified she had	A 407	Immediate Actions: • A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of the that review, the triage policy was revised so that the triage registered nurse notifies medical provider if the patient is experiencing pain ≥ 7/10 and follows physicians order to initiate pain medication for pain relief (Attachment P). 6/18/07 • The ED nurse manager provided in-service on the revised triage policy #114. (Attachment D) 6/18/07 • The ED nurse manger provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain which requires interventions based on the pain policy (Attachment N). 6/5/07 • The ED Nurse Manager provided education to the ED staff regarding the requirement of administering pain medication in a timely fashion in accordance with policy (Attachment V). 6/8/07 Permanent Action: The monitoring described below will be used to assume the continuing effectiveness of these corrective actions. Monitoring: • The ED nurse manager or designee will review ten randomly selected charts each week to assess for appropriateness of triage acuity score based on the Emergency Severity Index, timely reassessment based on triage level and their scores adjusted accordingly, and pain intervention based on pain score. Deficiencies will be addressed by the ED Nurse Manager. Data from the weekly reviews will be presented to ED Collaborative. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary, and report it to the Quality Council and Executive Committee and as appropriate, the Governing Body. Positions Responsible: Chief Nursing Officer ED Nurse Manager	

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A 407	Continued From page 29 sharp pain of 10 on a 1-10 scale. No pain intervention were initiated in the triage area. The patient was taken to the treatment area five hours later at 1815 and received pain medication one hour later. Approximately 20 hours after she presented to the ED, at 0830 hours on 5/1/07, a general surgery consultation was provided to evaluate the acute abdominal pain for Patient #2. The closed medical record for Patient #2 revealed "Dr."at bedside. However, review of the record revealed that the general surgery consultation had been provided by a Physician Assistant (PA-C). There was no documentation to reveal that provision of emergency consultations by a PA-C was approved and consistent with the rules and regulations, the medical staff bylaws of the hospital, and the credentialing process of a mid-level practitioner. The patient was admitted to the hospital and had surgery for an exploratory laparotomy ventral hernia repair. 8. Patient #3 came to the emergency department of the hospital at approximately 2040 hours on 4/30/07. Patient #3 stated that he was seeing aliens and devils. He was dropped off by his family. At triage the nurse documented the patient had suicidal ideations with a plan to drink bleach. The nurse triaged the patient as a category 3 (stable major illness) and left him in the lobby for over one hour before taking him back to the treatment area. Patient #3 was evaluated by the emergency department physician at 0500 hours on 5/1/07, a delay of almost 7 hours. No psychiatric treatment or consultation was provided. Approximately 6 hours later, at 1055 hours on 5/1/07, an evaluation by a mental health professional was requested. The mental health evaluation was not completed until four hours later at 1500 hours; 17	A 407	~~The ED Nurse Manager~~ provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain, which requires intervention based on the pain policy. This information must be documents in the patient's medical record (Attachment H). A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triaging process was re-designed to provide for amore timely medical screening examination. This process includes the following: o The triage nurse and registration clerk are co-located so that the triaging process and the registration process can occur simultaneously. o A physician will be available to the triaging area to perform immediate medical screening examinations for patients who are identified as a Level 3. Upon completion of the medical screening examination, based on the patient's clinical presentation, tests and treatments (including pain management) will be ordered and carried out. o Patients who are identified as a Level 1 and 2 at the time of triage will be brought back to the emergency treatment area. At the time of arrival, the ED charge nurse will notify the physician of the patient's arrival by placing the patient's pseudo name on the white board along with the patient's priority number. The physician will acknowledge the patient by initialing the white board and will perform the medical screening examination as soon as possible. If a patient's condition is critical the RN will verbally notify the physician. o The Chief Medical officer notified the ED Medical Director that physician assistants shall no longer perform medical screening examinations (Attchment B). o The ED Medical Director informed each physician assistant, by e-mail, that they may no longer perform ~~medical screening examinations~~	6/19/07 6/19/0 6/8/07 6/7/07

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A 407	Continued From page 29 sharp pain of 10 on a 1-10 scale. No pain intervention were initiated in the triage area. The patient was taken to the treatment area five hours later at 1815 and received pain medication one hour later. Approximately 20 hours after she presented to the ED, at 0830 hours on 5/1/07, a general surgery consultation was provided to evaluate the acute abdominal pain for Patient #2. The closed medical record for Patient #2 revealed "Dr." at bedside. However, review of the record revealed that the general surgery consultation had been provided by a Physician Assistant (PA-C). There was no documentation to reveal that provision of emergency consultations by a PA-C was approved and consistent with the rules and regulations, the medical staff bylaws of the hospital, and the credentialing process of a mid-level practitioner. The patient was admitted to the hospital and had surgery for an exploratory laparotomy ventral hernia repair. 8. Patient #3 came to the emergency department of the hospital at approximately 2040 hours on 4/30/07. Patient #3 stated that he was seeing aliens and devils. He was dropped off by his family. At triage the nurse documented the patient had suicidal ideations with a plan to drink bleach. The nurse triaged the patient as a category 3 (stable major illness) and left him in the lobby for over one hour before taking him back to the treatment area. Patient #3 was evaluated by the emergency department physician at 0500 hours on 5/1/07, a delay of almost 7 hours. No psychiatric treatment or consultation was provided. Approximately 6 hours later, at 1055 hours on 5/1/07, an evaluation by a mental health professional was requested. The mental health evaluation was not completed until four hours later at 1500 hours; 17	A 407	**Permanent Action:** The monitoring processes described below will be used to assure the effectiveness of these corrective actions. **Monitoring:** Ten randomly selected medical records will be reviewed daily to track the time from triage to medical screening examination. Data from these daily reviews will be presented to the ED Collaborative Practice Committee and the process will be re-evaluated as a result of this review. Data will also be presented to the Performance Improvement Committee monthly, which will evaluate it, develop corrections actions as necessary, and report it to the Executive Committee and as appropriate to the Governing body. Once the Executive Committee concludes that the process is stable, the daily record review will concert to a monthly review. **Position Responsible:** ED Medical Direcotor ED Nurse Manager	

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	050578	A. BUILDING _____ B. WING _____	C 06/07/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MLK/MARTIN LUTHER KING JR GEN HOSPITAL	12021 S WILMINGTON AVE LOS ANGELES, CA 90059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 407	Continued From page 30 hours after he presented to the ED. The mental health professional determined the Patient #26enied being suicidal at the time of the evaluation. Patient #3 was discharged home at 2100 hours without receiving treatment. The hospital thus failed to ensure that the provision of emergency services had been provided within timeframes consistent with acceptable safety for psychiatric patients. 9. The medical record for Patient #9 showed she presented to the ED at approximately 1400 hours on 4/30/07 complaining of having a glass object "stuck" in her vagina. She complained of moderate aching pain. The nurse documented a PA-C saw the patient in triage at 1540 hours, but there was no documentation by the PA-C about the determination if an emergent medical condition existed. There was no treatment ordered or provided for the patient's pain. There was no documented re-assessment of Patient #9, until approximately 6 and 1/2 hours later, when a nurse saw her. A gynecological examination of the patient was ordered by the PA-C at approximately 2100 hours. The nurse documented an exam was done by a physician but there was no documentation by a member of the medical staff of the patient's condition and/or treatment received. The patient was discharged at 2230 hours. The discharge instructions were written by the PAC. 10. Additional review of the medical record for Patient #29 identified she came to the ED with the paramedics at approximately 1700 hours on 4/28/07, after taking 10 Elavil pills (antidepressant) in a suicide attempt. There was a one-hour delay in the medical screening examination and any stabilizing treatment. The	A 407	Background: • A further review of the chart disclosed that both an ED physician exam and a consultation with a GYN were documented; however, they were misfiled in the wrong section of the chart. Immediate Action: • A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triage policy was revised so that the triage registered nurse notifies medical provider if the patient is experiencing pain ≥ than 7/10 and follows physicians order to initiate pain medication for pain relief regardless of triage acuity level. The ED Nurse Manager provided in-service on the revised triage policy #114. • The ED Nurse Manager provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain, which requires interventions based on the pain policy. Permanent Action: • The monitoring process described below will be used to assure the continuing effectiveness of these corrective actions. The ED Nurse Manager will address deficiencies with responsible personnel. Monitoring: • The ED Nurse Manager or designee will review ten randomly selected charts each week to assess ED patients for appropriateness of pain intervention based on pain score. Deficiencies will be addressed by the ED Nurse Manager. Data fro the weekly reviews will be presented to the ED Collaborative Committee. Data will also be presented to the QPIC monthly, which will evaluate it, create corrective actions as necessary and report it to Quality Council and Executive Committee, and as appropriate to Governing Body. Once audits demonstrate consistency, monitoring will be limited to ten charts monthly.	

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LAC/MARTIN LUTHER KING JR GEN HOSPITAL	12021 S WILMINGTON AVE LOS ANGELES, CA 90059

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A 407	Continued From page 31 patient was later admitted to the hospital then transferred to a psychiatric hospital.	A 407	**Permanent Action:** The monitoring processes described below will be used to assure the effectiveness of these corrective actions. **Monitoring:** Starting July 1, 2007, Utilization Review Staff will review at least 15% of patients weekly to track and trend data from arrival to triage and arrival to medical screening exam. Time of arrival to time of discharge is tracked electronically through the Affinity System for all patients and trended weekly. The information goes to the Emergency Department Collaborative Committee for evaluation. The reports will go to both the ED Committee and the Quality/Performance Improvement Committee (QPIC), which will report this to the Executive Committee or Quality Council respectively, and then to the Governing Body. Position Responsible: ED Medical Direcotor ED Nurse Manager	